

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12089

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12085

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 41 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 16 Queen City Pavement, Cumberland		d. STREET ADDRESS 16 Queen City Pavement	
3. NAME OF DECEASED (Type or print) Harold Ashworth		4. DATE OF DEATH Month September Day 2 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 27, 1901
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 01 Days 1	
11. BIRTHPLACE (State or foreign country) Bolton, Lancashire, England		12. CITIZEN OF WHAT COUNTRY? England	
13. FATHER'S NAME Thomas Ashworth		14. MOTHER'S MAIDEN NAME Pamela Cooper	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-07-1536	
17. INFORMANT Baltimore Pike		Cumberland, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Coronary Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) Coronary Sclerosis (c) Coronary Sclerosis			INTERVAL BETWEEN ONSET AND DEATH Hours ---
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED		Sept. 2, 1966	
23a. 8 BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-4-66	
23c. NAME OF CEMETERY OR CREMATORY Zion Memorial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Maryland	
24. FUNERAL DIRECTOR Dale L. Merritt		ADDRESS 404 Decatur St. Cumb., Md.	
25a. REC'D BY REGISTRAR DATE SEP 6 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

12003

12003

[Faint, illegible text and markings covering the page, possibly bleed-through from the reverse side. Includes a faint rectangular stamp in the upper right quadrant.]

12086

CERTIFICATE OF DEATH

12080

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b CUMBERLAND			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROBERT Middle F. Last ASKEY				4. DATE OF DEATH Month SEPTEMBER Day 13 Year 1966			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-1-1900	
9. AGE (In years last birthday) 66 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, when if retired) Retired Salesman		10b. KIND OF BUSINESS OR INDUSTRY Menaway Co		11. BIRTHPLACE (County & State, or foreign country) W. VA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HARRY ASKEY (D)		14. MOTHER'S MAIDEN NAME ABBIE (D) Hilshrie		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT PT'S CHART		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Shutdown due to shock 4201 DUE TO (b) Myocardial infarction, protein, DUE TO acute (c) coronary thrombosis - arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/10 , 19 66 , to 9/13 , 19 66 , that (I) (we) last saw the deceased alive on 9/13 , 19 66 , and that death occurred at 5:47 M, from causes and on the date stated above.							
22a. SIGNATURE Dr. S. G. Weisman				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/13/66	
22c. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN, M.D.				22d. ADDRESS 59 GREENE ST. CUMBERLAND, MARYLAND.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/16/66		23c. NAME OF CEMETERY OR CREMATORY Zion Memo. Cem		23d. LOCATION (City or Town) (County) (State) Cumberland MD	
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb. MD.				25a. REC'D BY REGISTRAR DATE SEP 16 1966		25b. REGISTRAR'S SIGNATURE J. Charles Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

2000

09052

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12091 CERTIFICATE OF DEATH 12087											
1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Oldtown</u>				c. LENGTH OF STAY IN 1b <u>Years</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Oldtown</u>			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 1</u>					d. STREET ADDRESS <u>Route 1</u>						
3. NAME OF DECEASED (Type or print) First <u>Hazel</u> Middle <u>Elizabeth</u> Last <u>Athey</u>			4. DATE OF DEATH Month <u>September</u> Day <u>10</u> Year <u>1966</u>								
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 25, 1893</u>		9. AGE (in years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Allegany Co., Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		
13. FATHER'S NAME <u>Henry Snyder</u>					14. MOTHER'S MAIDEN NAME <u>Mrs. Emma Kirtley</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>220-34-1966</u>		17. INFORMANT <u>Mrs. Francis Hess, Route 1, Oldtown, Md</u>					Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, metastatic secondary</u> 1538 DUE TO (b) <u>to below carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 21</u> , 19 <u>64</u> , to <u>9-10</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8-8</u> , 19 <u>66</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Carlton Brinsfield</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>CARLTON BRINSFIELD MD</u>					22d. ADDRESS <u>401 DECATUR ST</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Sept 13, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Luke's Lutheran Cem</u>			23d. LOCATION (City, town or county) (State) <u>Cumberland, Maryland</u>			
24. FUNERAL DIRECTOR <u>John J. Hafer</u>					ADDRESS <u>230 Balto Ave., Cumberland, Md</u>		25a. REC'D BY REGISTRAR <u>SEP 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

2021

52121

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12092

CERTIFICATE OF DEATH

12088

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE W. VA. b. COUNTY HAMPSHIRE		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY in 1b 23 HRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SPRINGFIELD	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL			d. STREET ADDRESS Rural		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) MR. CHARLES L. BAZZLE			4. DATE OF DEATH Month SEPT. Day 24 Year 66		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/1/94	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (County & State, or foreign country) VIRGINIA	
13. FATHER'S NAME MICHAEL BAZZLE			14. MOTHER'S MAIDEN NAME AMANDA BAKER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Diabetic Acidosis DUE TO (c) Diabetes Mellitus					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 9/23 , 19 66 to 9/24 , 19 66 , that (I) (we) last saw the deceased alive on 9/24 , 19 66 , and that death occurred at 1:00 PM on 9/24 , 19 66 , from causes and on the date stated above.					
22a. SIGNATURE Leo Schaffer		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/26/66	
22c. PHYSICIAN'S NAME (Type) DR. LEO LEY		22d. ADDRESS 456 N. CENTRE ST. CUMBERLAND, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-27-66	23c. NAME OF CEMETERY OR CREMATORY Springfield Hill		23d. LOCATION (City or Town) (County) (State) Springfield Hampshire, W. Va.	
24. FUNERAL DIRECTOR Leo Schaffer		ADDRESS Romney, W. Va.		25a. REC'D BY REGISTRAR DATE SEP 30 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

12088

CERTIFICATE OF DEATH

12088

RECEIVED

CHURCHLAND

RECEIVED HOSPITAL

MR.

CHARLES L. BAXTER

CHURCHLAND

MALE WHITE

CHURCHLAND

VIRGINIA

CHURCHLAND

CHURCHLAND

CHURCHLAND

CHURCHLAND

CHURCHLAND

CHURCHLAND

CHURCHLAND

12093

CERTIFICATE OF DEATH

13466

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Garrett</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN 1b <u>4 Days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Miners Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Savilla Edith Beeman</u>		4. DATE OF DEATH <u>Sept. 27,</u> 19 <u>66</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/10/1910</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE (In years last birthday) <u>56</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____
11. BIRTHPLACE (County & State, or foreign country) <u>Somerset Co., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Dan Stevanus</u>		14. MOTHER'S MAIDEN NAME <u>Nora Kendall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Mr. Henry Beeman, Grantsville, Md.</u>		Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinomatosis</u> 1750 DUE TO (b) <u>Primary ovarian carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>18 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9-22-</u> , 19 <u>66</u> , to <u>9-26-</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9-25-</u> , 19 <u>66</u> , and that death occurred at <u>4:35 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>G. Paige Strong</u>		22b. DATE SIGNED <u>10/13/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. Paige Strong</u>		22d. ADDRESS <u>Frostburg, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/29/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul, Pa. Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>R.D. Meyersdale Somerset Pa.</u>
24. FUNERAL DIRECTOR <u>Don Newman</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 17 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1946

CERTIFICATE OF DEATH

1946

THE STATE OF TEXAS, COUNTY OF DALLAS, SS. I, the undersigned, a Justice of the Peace for said County, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of said County.

12094

CERTIFICATE OF DEATH

12089

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>52 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. Memorial Hospital</u>		d. STREET ADDRESS <u>574 Winifred Road</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph M. Breighner</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>20</u> , Year <u>66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 7, 1913</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Cumberland, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Roy M. Breighner</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Dove</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes War II</u>		16. SOCIAL SECURITY NO. <u>214-05-8613</u>	
17. INFORMANT <u>Mrs. Eleanor Breighner</u>		Address <u>Cumberland, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease.</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 16, 1952</u> , to <u>June 23, 1966</u> that (I) (we) last saw the deceased alive on <u>Sept. 15, 1966</u> , and that death occurred at <u>3 PM</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>Sept. 20, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. G. Overton Himmelwright</u>		22d. ADDRESS <u>133 Virginia Ave., Cumberland, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept. 23, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Davis Memorial Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Cumberland, Md. Allegany</u>
24. FUNERAL DIRECTOR <u>James F. Scarpelli, Cumberland, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 26 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15084

STATEMENT OF DEATH

15084

COMMONWEALTH OF MASSACHUSETTS

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF VITAL RECORDS

STATE OF MASSACHUSETTS

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF VITAL RECORDS

STATE OF MASSACHUSETTS

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF VITAL RECORDS

STATE OF MASSACHUSETTS

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF VITAL RECORDS

STATE OF MASSACHUSETTS

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF VITAL RECORDS

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any further information is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12095

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12090

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN lb Years			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS 111 N. Walnut Place			
3. NAME OF DECEASED (Type or print) Lily Mae Brown				4. DATE OF DEATH September 29 1966			
5. SEX Female		6. COLOR OR RACE Black		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 27, 1886	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME John Meigs				14. MOTHER'S MAIDEN NAME Elizabeth Wallace			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)				16. SOCIAL SECURITY NO. 220-10-2598D			
17. INFORMANT James L. Brown, 111 N. Walnut Place, Cumberland				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Coronary Sclerosis (c)				INTERVAL BETWEEN ONSET AND DEATH 30 Minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> September 29, 1966			
				DATE SIGNED Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF October 3, 1966		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
				22d. LOCATION (City, town, or country) Cumberland, Maryland		(State)	
23. FUNERAL DIRECTOR John J. Hater				24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Charles Judge			
ADDRESS John J. Hater, 230 Balto Ave., Cumberland, Md				DATE OCT 5 1966			

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12086

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12091

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Tennessee b. COUNTY Hawkins	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 3 Hrs. 35 Min.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Sherrell Burke		4. DATE OF DEATH Month Sept. Day 10, Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1945
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	9. AGE (In years last birthday) yrs. 21
11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Lee Burke		14. MOTHER'S MAIDEN NAME Virginia Haygood	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes At Present		16. SOCIAL SECURITY NO. 413-68-1760	
17. INFORMANT Hugh E. Housewright, Jr.		Address Surgoinsville Tenn.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial Hemorrhage 8164 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Skull Fracture; Transection of second cervical vertebrae (c)			INTERVAL BETWEEN ONSET AND DEATH About 4 Hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile collision	
20c. TIME OF INJURY Month, Day, Year Hour 6:00 PM Sept. 10 19 66		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route # 28, Near Wiley Ford, Mineral, WV		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 16, 1966	
23c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery		23d. LOCATION (City or Town) (County) (State) Surgoinsville, Tenn.	
24. FUNERAL DIRECTOR Philip B. Wendt 121 Memorial Ave. Cumb. Md.		25a. REC'D BY REGISTRAR SEP 14 1966	
25b. REGISTRAR'S SIGNATURE f Charles Judge		22. DATE SIGNED September 10, 1966	

19081

19082

12097

CERTIFICATE OF DEATH

12092

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY BEDFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 48 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS HYNDMAN	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle M. Last BURKETT		4. DATE OF DEATH Month SEPTEMBER Day 22 Year 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-31-87
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BROOK RAILROAD Employee		10b. KIND OF BUSINESS OR INDUSTRY Bedford Co. Penna	
11. BIRTHPLACE (County & State, or foreign country) Bedford Co. Penna		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LEVIAH BURKETT		14. MOTHER'S MAIDEN NAME CATHERINE LOWERY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 705-09-5919	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) multiple metastases DUE TO (b) Adeno Carcinoma of Prostate DUE TO (c) 177X		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-8-66 , 19 66 , that (I) (we) lost saw the deceased alive on 1-22 , 19 66 , and that death occurred at 1:45 A.M. 9-22 , 19 66 , from causes and on the date stated above.			
22a. SIGNATURE Dr. J. Valdes		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. J. VALDES		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Sept. 25 1966	
23c. NAME OF CEMETERY OR CREMATORY PALO Alto Cemetery		23d. LOCATION (City or Town) (County) (State) Hyndman Bedford Co. PA	
24. FUNERAL DIRECTOR Howey N. Zeigler Hyndman, PA		25a. REC'D BY REGISTRAR SEP 29 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

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DEPARTMENT OF HEALTH

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12098

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12093

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
c. LENGTH OF STAY IN 1b 65 years		d. STREET ADDRESS 38 VIRGINIA AVENUE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle M. Last CAGE		4. DATE OF DEATH Month SEPTEMBER Day 15 Year 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-11-82
9. AGE (In years and days) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) MARTINSBURG, W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles E. Cage		14. MOTHER'S MAIDEN NAME Leah F. Staubs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes Peace Time		16. SOCIAL SECURITY NO.	
17. INFORMANT PT'S CHART		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural Hemorrhage DUE TO 9040 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Contusions of Brain DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 4 days 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at Home	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 9:00 Sept. 11 19 66	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Cumberland, Alleg. Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED September 15, 1966		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 18, 1966	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
23d. LOCATION (City or Town) Cumberland, Md. Allegany		(County) (State)	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS	
25a. REC'D BY REGISTRAR SEP 19 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
12099			MEDICAL EXAMINER'S CERTIFICATE OF DEATH				12094		
1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt. # 6 Cumberland,</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D. O. A. Sacred Heart Hosp.</u>					d. STREET ADDRESS <u>Rawlings,</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Vance</u> Middle <u>Louie</u> Last <u>Chucci</u>					4. DATE OF DEATH Month <u>Sept.</u> Day <u>17</u> Year <u>1966</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>Jan. 25, 1925</u>		9. AGE (In years last birthday) yrs. <u>41</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>		11. BIRTHPLACE (State or foreign country) <u>McCoole, Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Henry Chucci</u>					14. MOTHER'S MAIDEN NAME <u>Lula Leatherman</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes,</u> <u>W. W. # 2</u>		16. SOCIAL SECURITY NO. <u>721-16-9533</u>		17. INFORMANT <u>Mrs. Betty L. Chucci Rt. # 6 Cumb. Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>CORONARY SCLEROSIS WITH THROMBOSIS</u> (c) <u>-----</u>								INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.					22. DATE SIGNED <u>September 17, 1966</u>				
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>					Address (Street, city, town, or county) <u>Cumberland, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/20/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Abe Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>nr. Ridgeley, Mineral W. Va.</u>			
24. FUNERAL DIRECTOR <u>H. Wayne George Cumberland, Maryland</u>					25a. REC'D BY REGISTRAR DATE <u>SEP 22 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

15084

15084

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12100

12095

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE W.VA. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 1 DAY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. STREET ADDRESS RT. #2, BOX 77	
3. NAME OF DECEASED (Type or print) First EMMETT Middle L. Last COX		4. DATE OF DEATH Month SEPTEMBER Day 9 Year 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-8-1966
9. AGE (In years last birthday) yrs. 23		10. IF UNDER 1 YEAR Months 23 Days 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME COX, LEONARD LEE		14. MOTHER'S MAIDEN NAME HAZEL A. KESNER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL-CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Prematurity 24 wks DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat White <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 6:05 A.M. from causes and on the date stated above.			
22a. SIGNATURE Julius S. Whitworth M.D.		22b. DATE SIGNED 9/12/1966	
22c. PHYSICIAN'S NAME (Type) DR. F.B. WHITWORTH		22d. ADDRESS 305 WASHINGTON ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 10, 1966	23c. NAME OF CEMETERY OR CREMATORY Ft Ashby Cemetery	23d. LOCATION (City or Town) (County) (State) Ft Ashby, W. Va.
24. FUNERAL DIRECTOR Allen M. Rotruck, Keyser W. Va.		25a. REC'D BY REGISTRAR SEP 15 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (The funeral director should be notified by the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

15100

CERTIFICATE OF DEATH

15100

ALL EARS

CO. F. 100

100

KEYSTONE, W. VA.

MEMORIAL HOSPITAL

RT. 12, BOX 12

EMERIT

100

WHITE

100-1000

CO. LEONARD LEE

HAIR A. REYNOLD

100

MEMORIAL HOSPITAL

2/15/1900

Ft. Ashby Cemetery

Ft. Ashby, W. Va.

Sept. 10, 1900

buried

DR. F. L. WILKINSON

100 WASHINGTON ST., CORNER A. D. N.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12102

12096

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
c. LENGTH OF STAY IN 1b 25 Years				d. STREET ADDRESS 411 Furnace Street			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 411 Furnace Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Jerome Patrick Creegan				4. DATE OF DEATH Month Day Year September 22 19 66			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 19, 1905	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Employee Queen City Brewing Co.			10b. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Edward Creegan				14. MOTHER'S MAIDEN NAME Lucy Simpson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-05-9867		17. INFORMANT Address 411 Furnace St Cumberland, Md Mrs. Germaine Creegan			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infaretion DUE TO (b) Arteriosclero tic Heart Disease DUE TO (c) Moments							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 19 61 to Sept. 22 19 66 that (I) (we) lost saw the deceased alive on Aug. 4 19 66 and that death occurred at 9:30 am Sept. 22, 1966 M, from causes and on the date stated above.							
22a. SIGNATURE Wayne C. Spiggle				22b. DATE SIGNED 9/23/66		22c. PHYSICIAN'S NAME (Type) Wayne C. Spiggle	
22d. ADDRESS m.n. 126 N. Smallwood Street, Cumb.				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/24/66		23c. NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland	
24. FUNERAL DIRECTOR Ruth E. Silcox				25a. REC'D BY REGISTRAR SEP 27 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2000

GOIST

12101

CERTIFICATE OF DEATH

12097

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 2 Weeks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS RT#1, BOX 464	
3. NAME OF DECEASED (Type or print) First ELLEN Middle NORA Last CREEK		4. DATE OF DEATH Month SEPT. Day 16 Year 19 66	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 5, 1986
9. AGE (In years last birthday) yrs. 80		10. IF UNDER 1 YEAR Months 16 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE At Home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY LEE(DECEASED)		14. MOTHER'S MAIDEN NAME CHARLOTTE RICE (DECEASED)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-10-7764-D	
17. INFORMANT PATTI NTS CHART		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR HEMORRHAGE DUE TO (b) ESSENTIAL HYPERTENSION DUE TO (c) 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-2 , 19 66 , to 9-16 , 19 66 , that (I) (we) last saw the deceased alive on 9-16 , 19 66 , and that death occurred at 4P M, from causes and on the date stated above.			
22a. SIGNATURE <i>Dr. M. Glick</i>		22b. DATE SIGNED 9-17-66	
22c. PHYSICIAN'S NAME (Type) DR. M. GLICK AND DR. W. SPIGGLE		22d. ADDRESS N. SMALLWOOD ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/18/66	23c. NAME OF CEMETERY OR CREMATORY Centerville Fshp Cemetery	23d. LOCATION (City or Town) (County) (State) Centerville Bedford Penna
24. FUNERAL DIRECTOR H. Lee Silcox		25a. REC'D BY REGISTRAR SEP 19 1966	
ADDRESS Cumberland Maryland 21502		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, within any event, within 72 hours after death.

15081

UNITED STATES GOVERNMENT

40391

1. NAME OF THE PARTY		2. ADDRESS	
3. CITY		4. STATE	
5. ZIP CODE		6. COUNTRY	
7. PHONE NUMBER		8. FAX NUMBER	
9. E-MAIL ADDRESS		10. OTHER CONTACT INFORMATION	
11. DATE OF BIRTH		12. DATE OF DEATH	
13. DATE OF MARRIAGE		14. DATE OF DIVORCE	
15. DATE OF CITIZENSHIP		16. DATE OF RESIDENCE	
17. DATE OF ENTRY		18. DATE OF EXIT	
19. DATE OF DEPARTURE		20. DATE OF RETURN	
21. DATE OF ARRIVAL		22. DATE OF DEPARTURE	
23. DATE OF DEPARTURE		24. DATE OF RETURN	
25. DATE OF ARRIVAL		26. DATE OF DEPARTURE	
27. DATE OF DEPARTURE		28. DATE OF RETURN	
29. DATE OF ARRIVAL		30. DATE OF DEPARTURE	
31. DATE OF DEPARTURE		32. DATE OF RETURN	
33. DATE OF ARRIVAL		34. DATE OF DEPARTURE	
35. DATE OF DEPARTURE		36. DATE OF RETURN	
37. DATE OF ARRIVAL		38. DATE OF DEPARTURE	
39. DATE OF DEPARTURE		40. DATE OF RETURN	
41. DATE OF ARRIVAL		42. DATE OF DEPARTURE	
43. DATE OF DEPARTURE		44. DATE OF RETURN	
45. DATE OF ARRIVAL		46. DATE OF DEPARTURE	
47. DATE OF DEPARTURE		48. DATE OF RETURN	
49. DATE OF ARRIVAL		50. DATE OF DEPARTURE	
51. DATE OF DEPARTURE		52. DATE OF RETURN	
53. DATE OF ARRIVAL		54. DATE OF DEPARTURE	
55. DATE OF DEPARTURE		56. DATE OF RETURN	
57. DATE OF ARRIVAL		58. DATE OF DEPARTURE	
59. DATE OF DEPARTURE		60. DATE OF RETURN	
61. DATE OF ARRIVAL		62. DATE OF DEPARTURE	
63. DATE OF DEPARTURE		64. DATE OF RETURN	
65. DATE OF ARRIVAL		66. DATE OF DEPARTURE	
67. DATE OF DEPARTURE		68. DATE OF RETURN	
69. DATE OF ARRIVAL		70. DATE OF DEPARTURE	
71. DATE OF DEPARTURE		72. DATE OF RETURN	
73. DATE OF ARRIVAL		74. DATE OF DEPARTURE	
75. DATE OF DEPARTURE		76. DATE OF RETURN	
77. DATE OF ARRIVAL		78. DATE OF DEPARTURE	
79. DATE OF DEPARTURE		80. DATE OF RETURN	
81. DATE OF ARRIVAL		82. DATE OF DEPARTURE	
83. DATE OF DEPARTURE		84. DATE OF RETURN	
85. DATE OF ARRIVAL		86. DATE OF DEPARTURE	
87. DATE OF DEPARTURE		88. DATE OF RETURN	
89. DATE OF ARRIVAL		90. DATE OF DEPARTURE	
91. DATE OF DEPARTURE		92. DATE OF RETURN	
93. DATE OF ARRIVAL		94. DATE OF DEPARTURE	
95. DATE OF DEPARTURE		96. DATE OF RETURN	
97. DATE OF ARRIVAL		98. DATE OF DEPARTURE	
99. DATE OF DEPARTURE		100. DATE OF RETURN	

THIS IS A COPY OF THE ORIGINAL DOCUMENT
AND IS NOT TO BE USED FOR ANY OTHER PURPOSE
EXCEPT FOR THE PURPOSES FOR WHICH IT WAS
ISSUED.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12103

CERTIFICATE OF DEATH

12198

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		d. STREET ADDRESS 315 Emily Street	
3. NAME OF DECEASED (Type or print) Stanley E. Davies		4. DATE OF DEATH Month 9 Day 13 Year 1966	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/15/05
9. AGE (In years last birthday) yrs. 60		10. IF UNDER 1 YEAR Months 13 Days 13 Hours 13 Min. 13	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carmen Helper		10b. KIND OF BUSINESS OR INDUSTRY B & O RR	
11. BIRTHPLACE (County & State, or foreign country) Cumberland Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Davies (deceased)		14. MOTHER'S MAIDEN NAME Alice (deceased) Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 214-05-9373	
17. INFORMANT patient's chart		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary of liver with acute DUE TO (b) Uremia DUE TO (c) Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Week	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 13, 1966 to Sept 13, 1966 that (I) (we) last saw the deceased alive on Sept 13, 1966 , and that death occurred at 11:13 M, from causes and on the date stated above.			
22a. SIGNATURE Dr. B. Schindler		22b. DATE SIGNED 10-16-66	
22c. PHYSICIAN'S NAME (Type) Dr. B. Schindler		22d. ADDRESS 43 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 16, 1966	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE SEP 19 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

NEWS

20151

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

12104

CERTIFICATE OF DEATH

12099

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 36 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRANTSVILLE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JANE		Middle H.		Last DAVSS		4. DATE OF DEATH Month SEPTEMBER Day 10 Year 19 66	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-16-1923	
9. AGE (In years last birthday) 43 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) GARRETT CO. MD.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME DANIEL J. HUMMEL		14. MOTHER'S MAIDEN NAME SARAH E. TURNER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkins Sarcinoma Generalized DUE TO Conditions, if any, which gave rise to immediate cause (a). } (b) stating the underlying cause lost. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June , 19 66 to Sept , 19 66 that (I) (we) last saw the deceased alive on 10 Sept , 19 66 , and that death occurred at 4:35 PM , from causes and on the date stated above.							
22a. SIGNATURE F. B. Whitworth		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) DR. F. B. WHITWORTH		22d. ADDRESS 305 WASHINGTON ST.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/13/66		23c. NAME OF CEMETERY OR CREMATORY GRANTSVILLE		23d. LOCATION (City or Town) (County) (State) GRANTSVILLE GARRETT CO MD	
24. FUNERAL DIRECTOR Don Newman, Grantsville, Md		25a. REC'D BY REGISTRAR DATE SEP 16 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

12104

CERTIFICATE OF DEATH

12104

CARRITT

MARYLAND

ALLIANCE

CHARTERED

TO DATE

CHARTERED

OF SOCIAL SERVICE

DATE

DATE

1-18-1923

WHITE

WHITE

CARRITT CO. NO.

OFFICE

CARRITT CO. NO.

THE NATIONAL HOSPITAL, WASHINGTON, D.C.

DR. F. W. WHITWORTH

FOR WASHINGTON, D.C.

12105

CERTIFICATE OF DEATH

12100

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. LENGTH OF STAY IN 1b 15 Yrs	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		d. STREET ADDRESS Rt. 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) rural		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rose Middle Elizabeth Last Diehl		4. DATE OF DEATH Month Sept. Day 3 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 30, 1897
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H. Wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Tucker-W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James T. Shaffer		14. MOTHER'S MAIDEN NAME Susan R. Ryan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT William Diehl		Address Burlington, W. Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO atherosclerosis DUE TO Diabetes mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 10 yrs. 20 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Intake Cln		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1958 , to 1966 , that (I) (we) last saw the deceased alive on 9-2-66 19 66 , and that death occurred at 1 A.M. from causes and on the date stated above.			
22a. SIGNATURE William W. Lesh		22b. DATE SIGNED 9-3-66	
22c. PHYSICIAN'S NAME (Type) William W. Lesh		22d. ADDRESS Westernport, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/5/66	23c. NAME OF CEMETERY OR CREMATORY Queens Point	23d. LOCATION (City or Town) (County) (State) Keyser W. Va.
24. FUNERAL DIRECTOR Carl Brual		25a. REC'D BY REGISTRAR DATE SEP 3 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0151

2000

62002

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 841.

[illegible]

2003

• *Staphylococcus aureus*

•

5451-02-104

Figure 1

10/10/10 1:20 PM

William H. Hall

2

• **Importance**

2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 2681, 2682, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12106

Items #5,6,7,8 & 9 Filed #0287 10/7/66 pc

CERTIFICATE OF DEATH

12101

| | | | |
|---|------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Garrett</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Frostburg</u> | | c. LENGTH OF STAY IN lb
<u>3 Days</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Grantsville (Rural)</u> | | 11-2 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Miners Hospital</u> | | d. STREET ADDRESS
<u>11-2</u> | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>DORA</u> Middle <u>H.</u> Last <u>DURST</u> | | 4. DATE OF DEATH
Month <u>9</u> Day <u>-21</u> Year <u>1966</u> | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>May 4, 1881</u> |
| 9. AGE (In years last birthday)
<u>85</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own Home</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Avilton, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Sadris McKenzie</u> | | 14. MOTHER'S MAIDEN NAME
<u>Annie Chaney</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>220-52-9801</u> | |
| 17. INFORMANT
<u>Mrs. Carrie Britt, Frostburg, Md.</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Cardio-Vascular disease</u>
443X DUE TO
(b) <u>Hypertension</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO
(c) <u>Senility</u>
INTERVAL BETWEEN ONSET AND DEATH
<u>8 years</u>
<u>10 years</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Cellulitis of lower leg</u> | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>2-10</u> , 19 <u>60</u> , to <u>9-21</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9-20</u> 19 <u>66</u> , and that death occurred at <u>7:50 P.M.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>H.C. Diehl</u> M.D. | | 22b. DATE SIGNED
<u>9-21-66</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>H.C. Diehl, M.D.</u> | | 22d. ADDRESS
<u>39 W. MAIN ST. FROSTBURG, MD.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>9/24/66</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>New Germany Ref. Cem.</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Grantsville, Garrett, Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>Don Newman, Grantsville, Md.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>OCT 5 1966</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

10151

10151

10151

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

BP

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12107

CERTIFICATE OF DEATH

12102

| | | | |
|--|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY CO. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. LENGTH OF STAY IN lb
LA VALE | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
MEMORIAL HOSPITAL | | d. STREET ADDRESS
61 LA VALE COURT | |
| 3. NAME OF DECEASED (Type or print)
First ROSILLA MAY Middle DYCHE Last DYCHE | | 4. DATE OF DEATH
Month SEPT. Day 2 Year 19 66 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7-30-1889 |
| 9. AGE (In years last birthday)
77 yrs. | | 10. IF UNDER 1 YR. IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY
OWN HOME | |
| 11. BIRTHPLACE (County & State, or foreign country)
GREAT CACAPON, W. VA. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
WILLIAM CRAWFORD | | 14. MOTHER'S MAIDEN NAME
REBECCA A SIPES | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
NONE | |
| 17. INFORMANT
W. H. DYCHE | | Address
LA VALE, MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Degeneration
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Disease
DUE TO (c) Atherosclerosis, generalized | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 8/24 , 19 66 to 9/2 , 19 66 , that (I) (we) last saw the deceased alive on 9/2 , 19 66 , and that death occurred at 6:20 P.M. on 9/2 , 19 66 , and on the date stated above. | | | |
| 22a. SIGNATURE
Leo H. Ley | | 22b. DATE SIGNED
9/3/66 | |
| 22c. PHYSICIAN'S NAME (Type)
DR. LEO H LEY | | 22d. ADDRESS
456 N CENTRE ST. CUMBERLAND, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
SEPT. 5, 1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY
HILLCREST BURIAL PARK | | 23d. LOCATION (City or Town) (County) (State)
CUMBERLAND, MD. | |
| 24. FUNERAL DIRECTOR
BYRON KIGHT | | 25a. REC'D BY REGISTRAR
SEP 13 1966 | |
| ADDRESS
CUMBERLAND, MD. | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

13103

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

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12108
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12103

| | | | |
|--|----------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. LENGTH OF STAY IN 1b
25 years | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
SACRED HEART HOSPITAL | | d. STREET ADDRESS
448 BALTIMORE AVENUE | |
| 3. NAME OF DECEASED (Type or print)
First MARY Middle VERONICA Last FAHEY | | 4. DATE OF DEATH
Month 9 Day 9 Year 1966 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3-22-93 |
| 9. AGE (In years lost birthday)
73-73 yrs. | | IF UNDER 1 YEAR
Months | IF UNDER 24 HRS.
Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY
Dept. Store | |
| 11. BIRTHPLACE (County & State, or foreign country)
ELK GARDEN MD. W. Va. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John Joseph Fahey | | 14. MOTHER'S MAIDEN NAME
Margaret Ellen Carney | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
PT'S CHART | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis
1530
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) Carcinoma Cecum
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> ot work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 6/5 , 19 66 , to 9/9 , 19 66 , that (I) (we) lost saw the deceased alive on 6/5 , 19 66 , and that death occurred at 5:45 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Leo Fahey | | 22b. DATE SIGNED
9/9/66 | |
| 22c. PHYSICIAN'S NAME (Type)
DR. L. LEY, M.D. | | 22d. ADDRESS
456 N. CENTRE STREET CUMBERLAND, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Sept. 12, 1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY
St. Patrick's Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Cumberland Md. Allegany | |
| 24. FUNERAL DIRECTOR
James F. Scarpelli, Cumberland, Md. | | 25a. REC'D BY REGISTRAR
SEP 14 1966 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|---|---|--|--|---|---|---|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 12109 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | 12104 | | | | |
| 1. PLACE OF DEATH
o. COUNTY <u>Allegany</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rt. # 4 Cumberland,</u> | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Memorial Hosp.</u> | | | | | d. STREET ADDRESS
<u>Christie Rd.</u> | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Francis</u> Middle <u>Patrick</u> Last <u>Fairall</u> | | | | | 4. DATE OF DEATH
Month <u>Sept.</u> Day <u>18</u> Year <u>19 66</u> | | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Aug. 26, 1919</u> | | 9. AGE (In years last birthday) yrs. <u>47</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Mail rm. employee</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Newspaper</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Cumberland, Maryland</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | | |
| 13. FATHER'S NAME
<u>John Fairall</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>Sarah Schaffer</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>Yes, W. W. # 2</u> | | 16. SOCIAL SECURITY NO.
<u>214-07-1974</u> | | 17. INFORMANT
<u>Mrs. Lillian Fairall</u> Address <u>Rt. # 4 Cumberland, Md.</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>
<u>4201</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Coronary Sclerosis</u>
DUE TO (c) _____ | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>Sudden</u>
<u>----</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. <u>19</u> | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D. | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u> | | | | | 22. DATE SIGNED
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>September 18, 1966</u>
Address (Street, city, town, or county) <u>Cumberland, Md.</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>9/21/66</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Mount Herman Cemetery</u> | | | 23d. LOCATION (City or Town) (County) (State)
<u>nr. Cumberland Allegany Md.</u> | | |
| 24. FUNERAL DIRECTOR
<u>H. Wayne George</u> <u>Cumberland, Maryland</u> | | | | | 25a. REC'D BY REGISTRAR
DATE <u>SEP 22 1966</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | |

00151

00151

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---------------------------|---|---|---|--|----------------|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 12110 | | | | | 12105 | | | | |
| 1. PLACE OF DEATH
a. COUNTY Allegany | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Cumberland | | | c. LENGTH OF STAY IN 1b
11/8/1957 | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Westernport | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Allegany County Infirmary | | | | | d. STREET ADDRESS
Washington Street | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Marie | | | First Middle Last
Marie S. Frankland | | 4. DATE OF DEATH
September 6, 1966 | | Month Day Year | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
11/17/1873 | | 9. AGE (In years last birthday)
93 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Backnang, Germany | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Christian Stark | | | | | 14. MOTHER'S MAIDEN NAME
Christina Gensenjager | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT P.O. Box 599
Allegany County Infirmary records. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ① Hypertension, Cholelithiasis, Senile
443X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO ② Pneumonia
DUE TO ③ Arterio Sclerosis, General & Cerebral
DUE TO ④ Hypertension | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan., 1966, to Sept. 6, 1966, that (I) (we) last saw the deceased alive on Sept. 5, 1966, and that death occurred at 12:05 A.M., from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
Lee B. Mathews, M. D. | | | | 22b. DATE SIGNED
9/6/1966 | | | | 22c. PHYSICIAN'S NAME (Type)
Lee B. Mathews, M. D. | |
| 22d. ADDRESS
49 Greene St., Cumberland, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE THEREOF
9/8/66 | | 23c. NAME OF CEMETERY OR CREMATORY
Philos Com. | | 23d. LOCATION (City, town or county) (State)
Westernport Md. | |
| 24. FUNERAL DIRECTOR
Ed. Boal | | | | 24a. REC'D BY REGISTRAR
SEP 13 1966 | | 24b. REGISTRAR'S SIGNATURE
John Charles Jones | | | |

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12111

CERTIFICATE OF DEATH

12106

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Westernport | | c. LENGTH OF STAY IN lb
73 Years | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
107 Cromer Street | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Carrie Middle Elizabeth Last Gales | | 4. DATE OF DEATH
Month September Day 29 Year 1966 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 2, 1893 |
| 9. AGE (In years last birthday)
73 yrs. | | 10. IF UNDER 1 YEAR
Months 73 Days 14 Hours 14 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Henry Biddle | | 14. MOTHER'S MAIDEN NAME
Sarah Opal | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Virginia Miller | | Address
Westernport, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | INTERVAL BETWEEN ONSET AND DEATH
14 Hours |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Sept 28, 1966 , to Sept 29, 1966 , that (I) (we) last saw the deceased alive on Sept 28, 1966 , and that death occurred at 7:30 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Paul R. Wilson | | 22b. DATE SIGNED
Sept. 30, 1966 | |
| 22c. PHYSICIAN'S NAME (Type)
Paul R. Wilson, MD | | 22d. ADDRESS
Piedmont, W. Va. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
Oct. 1, 1966 | 23c. NAME OF CEMETERY OR CREMATORY
Philos Cemetery | 23d. LOCATION (City or Town) (County) (State)
Westernport Allegany, Md. |
| 24. FUNERAL DIRECTOR
E. L. Boal - Westernport, Md. | | 25a. REC'D BY REGISTRAR
DATE OCT 3 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and to be filed within 72 hours after death.

15108

STATE OF TEXAS

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

121112

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12107

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Virginia b. COUNTY Alexandria | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | c. LENGTH OF STAY IN lb
1 week | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Alexandria | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Sacred Heart Hospital | | d. STREET ADDRESS
153 Wesmond Drive | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type of print)
First Leona Middle Ethel Last Gormer | | 4. DATE OF DEATH
Month Sept. Day 17 Year 1966 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Jan. 16, 1917 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Seamstress | | 10b. KIND OF BUSINESS OR INDUSTRY
Garment | 9. AGE (In years last birthday) yrs. 49 |
| 11. BIRTHPLACE (State or foreign country)
Cumberland, Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Harley Robinette | | 14. MOTHER'S MAIDEN NAME
(Step) Ida Mae Robinette | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Mr. George Gormer, Alexandria, Va. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
DUE TO (b) Coronary Sclerosis with Thrombosis
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH
Hours |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Benedict Skitarelic M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Sept. 20, 1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Sunset Memorial Park | | 23d. LOCATION (City or Town) (County) (State)
Cumberland, Md. Allegany | |
| 24. FUNERAL DIRECTOR
James F. Scarpelli, Cumberland, Md. | | 25a. REC'D BY REGISTRAR
SEP 22 1966 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | 22. DATE SIGNED
September 17, 1966 | |

12101

12101

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

12113

CERTIFICATE OF DEATH

12108

| | | | |
|--|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Allegany
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. LENGTH OF STAY IN 1b
2/8/1962 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Allegany County Infirmary | | d. STREET ADDRESS
Church Street | |
| 3. NAME OF DECEASED (Type or print)
First Amelia Middle Jane Last Graney | | 4. DATE OF DEATH
Month September Day 18 Year 1966 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8/29/1878 |
| 9. AGE (In years last birthday)
88 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Midland, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
John Seymour | | 14. MOTHER'S MAIDEN NAME
Laura Warren | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT P.O.Box 599, Address Cumberland, Md
Allegany County Infirmary records. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 443X Hypertension, chronic degenerative, Senile
DUE TO (b) arteriosclerosis, generalized, & hypertension
DUE TO (c) fracture Rt hip (old)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) fracture left ankle (old) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 2/8/1962 , 19__ to 9/18/66 , 19__, that (I) (we) last saw the deceased alive on 9/17/66 , 19__, and that death occurred at P. M., from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Lee B. Mathews | | 22b. DATE SIGNED
9/19/1966 | |
| 22c. PHYSICIAN'S NAME (Type)
Lee B. Mathews, M. D. | | 22d. ADDRESS
49 Greene St., Cumberland, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
9-20-66 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Philos Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Westernport Alleg. Md | |
| 24. FUNERAL DIRECTOR
W.H. Fredlock Jr | | ADDRESS
Piedmont, W.Va | |
| 25a. REC'D BY REGISTRAR
SEP 23 1966 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | |

12118

REPORT OF DEATH

12118

NAME

DATE

AGE

SEX

EDUCATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE

PLACE

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12114

CERTIFICATE OF DEATH

12109

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|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland b. COUNTY
Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland, | | c. LENGTH OF STAY IN lb
58 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Sacred Heart Hospital | | d. STREET ADDRESS
340 Davidson Street | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Vernon Cornelius Hager | | 4. DATE OF DEATH
Month Day Year
Sept 2 19 66 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 31, 1897 |
| 9. AGE (In years last birthday)
69 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min.
2 19 66 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Ret. Grocer | | 10b. KIND OF BUSINESS OR INDUSTRY
Grocery Prop. | |
| 11. BIRTHPLACE (County & State, or foreign country)
Cumberland, Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
William Hager | | 14. MOTHER'S MAIDEN NAME
Edna M. Ardinger | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No. | | 16. SOCIAL SECURITY NO.
220-30-8768 | |
| 17. INFORMANT
Mrs. Anna Hager | | Address
340 Davidson St. Cumb. Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Industrial Obstruction
DUE TO (b) Generalized Abdominal Carcinomatosis
DUE TO (c) Carcinoma of Sigmoid Colon | | INTERVAL BETWEEN ONSET AND DEATH
2 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 6 July, 19 66 , to 2 Sept, 19 66 ; that (I) (we) last saw the deceased alive on 2 July, 19 66 , and that death occurred at 4:15 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
James B. Stegmaier | | 22b. DATE SIGNED
3 Sept 1966 | |
| 22c. PHYSICIAN'S NAME (Type)
J. G. Stegmaier, M.D. | | 22d. ADDRESS
122 South Centre Cumberland, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
9/5/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY
SS. Peter & Paul Cem. | | 23d. LOCATION (City or Town) (County) (State)
Cumberland, Allegany Md. | |
| 24. FUNERAL DIRECTOR
H. Wayne George | | 25a. REC'D BY REGISTRAR
DATE SEP 8 1966 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

12113

RECORDS OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|--|--|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | |
| 12115 | | | | | CERTIFICATE OF DEATH | | | | | 12110 | | | | |
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
c. LENGTH OF STAY IN 1b 32 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
d. STREET ADDRESS 1428 DOGWOOD CT. WHITE OAKS
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First CLIFTON Middle LUTHER Last HANLIN | | | | | 4. DATE OF DEATH
Month SEPT. Day 4 Year 19 66 | | | | | | | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 3-11-1908 | | 9. AGE (In years last birthday) 58 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist Helper | | | | 10b. KIND OF BUSINESS OR INDUSTRY Railroad | | 11. BIRTHPLACE (County & State, or foreign country) W.VA. -RIG | | | | 12. CITIZEN OF WHAT COUNTRY? U.S. A. | | | | |
| 13. FATHER'S NAME WILLIAM R HANLIN | | | | | 14. MOTHER'S MAIDEN NAME IDA V LAMBERT | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes | | | | 16. SOCIAL SECURITY NO. War II & Korean 220-10-7928 | | 17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Occlusion
DUE TO (b) Septicemia
DUE TO (c) Infection due to Hyperkalemia | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 24 hrs | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Dissecting Aortic Aneurysm | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 8/3 , 19 66 , to 9/4 , 19 66 , that (I) (we) last saw the deceased alive on 9/4/66 , 19 66 , and that death occurred at 9:55 PM from causes and on the date stated above. | | | | | | | | | | | | | | |
| 22a. SIGNATURE DR. OVERTON D HIMMELWRIGHT | | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 9/6/66 | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) DR. OVERTON D HIMMELWRIGHT | | | | | | 22d. ADDRESS 133 VIRGINIA AVE. CUMBERLAND, MD | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Sept. 7, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park | | 23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany | | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS James F. Scarpelli, Cumberland, Md. | | | | | | 25a. REC'D BY REGISTRAR DATE SEP 13 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | |

12111

12111

ALLEGANY

MARYLAND

ALLEGANY

CUMBERLAND

CUMBERLAND

1433 DOGWOOD CT. WHITE OAKS

MEMORIAL HOSPITAL

98 4 9495

HANLIN

CLINTON

0-11-1908

MALE WHITE

U.S.A.

U.S.A.

IDA V. LAMBERT

WILLIAM R. HANLIN

1201 W. SPRING, CUMBERLAND, MD.

DR. GERTON C. HINCHWRIGHT 133 VIRGINIA AVE. CUMBERLAND, MD.

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
|--|----------------------------------|---|--|--|--------------------------------|---|--------------------------------|
| 12116 | | | | 12111 | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE W. Va. b. COUNTY Mineral | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. LENGTH OF STAY IN 1b
? | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Wiley Ford | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
D. O.A. Memorial Hospital | | | | d. STREET ADDRESS | | 85-3 | |
| 3. NAME OF DECEASED (Type or print)
First Madlean Middle Ianes Last Hannas | | | | 4. DATE OF DEATH
Month Sept. Day 27 Year 19 66 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Jan. 27, 1909 | 9. AGE (In years last birthday) yrs.
57 | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (State or foreign country)
Green Ridge, Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
John Kiifer | | | | 14. MOTHER'S MAIDEN NAME
Estella Hutzell | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address
Mr. Herbert Hannas, Wiley Ford, W.Va. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Coronary Sclerosis
(c) ----- | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Sudden | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Benedict Skitarelic M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22. DATE SIGNED
September 27, 1966 | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Cumberland, Md. | |
| EXAMINER'S NAME (Type)
BENEDICT SKITARELIC, M.D. | | 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Sept. 30, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY
Sunset Memorial Park | |
| 24. FUNERAL DIRECTOR
James F. Scarpelli, Cumberland, Md. | | 23d. LOCATION (City or Town) (County) (State)
Cumberland, Md. Allegany | | 25a. REC'D BY REGISTRAR
OCT 3 1966 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

12111

12111

SECRET
CONFIDENTIAL

RECEIVED AT 12:00 PM, 1964
JANUARY 27, 1964

12117

CERTIFICATE OF DEATH

12112

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
ALLEGANY
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. LENGTH OF STAY IN lb
44 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
MEMORIAL HOSPITAL | | d. STREET ADDRESS
218 CECELIA ST. | |
| 3. NAME OF DECEASED (Type or print)
First
ROBERT
Middle
M
Last
HOPCRAFT | | 4. DATE OF DEATH
Month
SEPT
Day
17
Year
1966 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3-27-86 |
| 9. AGE (In years last birthday)
80 | | 10. IF UNDER 1 YEAR
Months
01
Days
1 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired B & O Machinist | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY
U.S.A. | |
| 13. FATHER'S NAME
JACK HOPCRAFT | | 14. MOTHER'S MAIDEN NAME
MOLLY RHODES | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
705-10-3792 | |
| 17. INFORMANT
MEMORIAL HOSPITAL, CUMBERLAND, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Diffuse Cerebrovascular Disease
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
(c) | | INTERVAL BETWEEN ONSET AND DEATH
3 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.
19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Cumby Alley Md | | 20f. (City or town) (County) (State)
Cumby Allegany Md | |
| 21. I certify that (I) (this hospital) attended the deceased from 4/7/66 , 19 to 9/17/66 , 19, that (I) (we) last saw the deceased alive on 9/17/66 , 19, and that death occurred at 8:40 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
DR. R.J. WILLIAMS | | 22b. DATE SIGNED
9/18/66 | |
| 22c. PHYSICIAN'S NAME (Type)
DR. R.J. WILLIAMS | | 22d. ADDRESS
122 S CENTER ST. CUMBERLAND, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
9/21/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY
St. Luke's Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Cumberland Allegany Maryland | |
| 24. FUNERAL DIRECTOR
Ruth E. Silcox Cumberland Maryland 21502 | | 25a. REC'D BY REGISTRAR
SEP 20 1966 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

12115

12115

CENTRAL OF DEATH

ALLIANCE

WELFARE

ALLIANCE

WELFARE

WELFARE

WELFARE

WELFARE

WELFARE

WELFARE

WELFARE

WELFARE

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WELFARE

WELFARE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|---|---|---|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 12118 Item #3 Film #G387 10/5/66 pc | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 12113 | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | c. LENGTH OF STAY IN 1b
2 DAYS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
MEMORIAL HOSPITAL | | | | | d. STREET ADDRESS
217 GRAND AVE. | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First HARVEY Middle R. Landis Last HOYLE | | | | | 4. DATE OF DEATH
Month SEPT. Day 16 Year 19 66 | | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
1-23-1890 | | 9. AGE (In years last birthday) yrs. 76 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
WEST VIRGINIA | | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
JOHN FRANK HOYLE | | | | | 14. MOTHER'S MAIDEN NAME
VIRGINIA MILLER | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Address MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Thrombosis
163X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) Carcinoma Left Lung DUE TO
(c) Arteriosclerosis | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Acute
4 months
5 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Mar. 18 66 to Apr. 16, 1966 , that (I) (we) last saw the deceased alive on Apr 16 19 66 , and that death occurred at 8:55 AM , from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
Clay F. Durrett | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
9/17/66 | | |
| 22c. PHYSICIAN'S NAME (Type) DR. CLAY DURRETT | | | | | 22d. ADDRESS
236 VIRGINIA AVE. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Sept. 19, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY
Davis Memorial Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Cumberland Md, Allegany | | | |
| 24. FUNERAL DIRECTOR
James F. Scarpelli, Cumberland, Md. | | | | | 25a. REC'D BY REGISTRAR
DATE SEP 22 1966 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

12113

CERTIFICATE OF DEATH

12113

ALLEGANY

MARYLAND

ALLEGANY

CLINCHFIELD

2 DAYS

CHIEF AND

217 GRAND AVE.

MEMORIAL HOSPITAL

HOPE

HUGLEY

1-23-1980

WHITE

WEST VIRGINIA

CHAMBERLAIN

VIRGINIA HILL

MEMORIAL HOSPITAL, CLINCHFIELD, MD

DR. CLAY WILSON

217 GRAND AVE.

12119

CERTIFICATE OF DEATH

12114

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. LENGTH OF STAY IN lb
62 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
MEMORIAL HOSPITAL | | d. STREET ADDRESS
700 LAFAYETTE AVENUE | |
| 3. NAME OF DECEASED (Type or print)
First JAMES Middle P. Last IRONS | | 4. DATE OF DEATH
Month SEPTEMBER Day 14 Year 1966 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9-24-1905 |
| 9a. AGE (In years and birthday)
60 yrs. | | 9b. IF UNDER 1 YEAR
Months 0 Days 14 Hours 19 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None Maintenance | | 10b. KIND OF BUSINESS OR INDUSTRY
hospital | |
| 11. BIRTHPLACE (County & State, or foreign country)
MARYLAND Cumberland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
SILAS IRONS | | 14. MOTHER'S MAIDEN NAME
STELLA SHIELDS | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
214-07-3204 | |
| 17. INFORMANT
MEMORIAL HOSPITAL -CUMBERLAND, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart Condition Arrest
DUE TO (b) Kimmelsteil Wilson Syndrome
DUE TO (c) lost
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | INTERVAL BETWEEN ONSET AND DEATH
yes |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 1954 , 19 to Sept , 19 66 , that (I) (we) last saw the deceased alive on Sept 13 , 19 66 , and that death occurred at 4:10 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
[Signature] | | 22b. DATE SIGNED
9/14/66 P. | |
| 22c. PHYSICIAN'S NAME (Type)
DR. G. O. HIMMELWRIGHT | | 22d. ADDRESS
133 VIRGINIA AVE., CUMBERLAND, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
Sept. 17, 1966 | 23c. NAME OF CEMETERY OR CREMATORY
Hillcrest Burial Park | 23d. LOCATION (City or Town) (County) (State)
Cumberland, Md. Allegany |
| 24. FUNERAL DIRECTOR
James F. Scarpelli, Cumberland, Md. | | 25a. REC'D BY REGISTRAR
DATE SEP 22 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

E152

1151

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12120

12115

| | | | |
|--|-------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG
c. LENGTH OF STAY IN 1b D. O. A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG
d. STREET ADDRESS 112 SPRING STREET
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First JAMES Middle MUIR Last KERR | | 4. DATE OF DEATH
Month SEPTEMBER Day 11 Year 19 66 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH DEC. 1, 1885 |
| 9. AGE (In years last birthday) 80 | | IF UNDER 1 YEAR
Months 0 Days 19 Hours 00 Min. 00 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DYE HOUSE | | 10b. KIND OF BUSINESS OR INDUSTRY CELANESE CORP. | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME THOMAS KERR | | 14. MOTHER'S MAIDEN NAME JEAN MUIR | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 214-01-3779 | |
| 17. INFORMANT MRS. VIRGINIA KERR | | Address FROSTBURG, MD. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY OCCLUSION
4201 DUE TO CORONARY SCLEROSIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| INTERVAL BETWEEN ONSET AND DEATH SUDDEN | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Benedict Skitarelic | | 22. DATE SIGNED RD 9, | |
| EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M. D. | | Address (Street, city, town, or county) CUMBERLAND, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF SEPT. 13, 1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY FB'G. MEMORIAL PARK | | 23d. LOCATION (City, town or county) (State) FROSTBURG, MD. | |
| 24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD. | | 25a. REC'D BY REGISTRAR SEP 19 1966 | |
| ADDRESS JOSEPH R. DURST, SR., FROSTBURG, MD. | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

99

0

2

77

15113

15113

James H. [illegible]

15113

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|----------------------------------|--|---|---|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | |
| 121121 | | | | | 121116 | | | | | |
| 1. PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) | | | | | |
| a. COUNTY
Allegany | | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lonaconing (Rural) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lonaconing (Rural) | | | d. STREET ADDRESS
Knapps Meadow | | |
| 3. NAME OF DECEASED (Type or print)
JOHN LEAKE | | | | | 4. DATE OF DEATH
9/6/1966 | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Dec, 31st. 1889 | | 9. AGE (In years last birthday)
76 yrs. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Miner | | | 10b. KIND OF BUSINESS OR INDUSTRY
(COAL) | | | 11. BIRTHPLACE (County & State, or foreign country)
Clay County, Indiana | | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Thomas Leake | | | | | 14. MOTHER'S MAIDEN NAME
Maude Winters | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> No | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Mrs. Thomas Powers, Lonaconing, MD. | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Dehydration
1538 DUE TO Intestinal Obstruction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Carcinoma large bowel
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) ACVD & congestive failure | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
7 days
21 days
14 mos. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m.
p.m.
19 | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from May 1965 to Sept 6, 1966 , that (I) (we) last saw the deceased alive on Sept 3, 1966 , and that death occurred at 5AM , from the causes and on the date stated above. | | | | | | | | | | |
| 22a. SIGNATURE
L.R. Miles, M.D. | | | | | 22b. DATE SIGNED
9-6-66 | | 22c. PHYSICIAN'S NAME (Type)
L.R. MILES, JR. M.D. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE THEREOF
9/8/1966 | | 23c. NAME OF CEMETERY OR CREMATORY
Sunset Memorial Park | | | 23d. LOCATION (City, town or county) (State)
Cumberland, MD. | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
GEORGE EICHHORN | | | | | 25a. REC'D BY REGISTRAR
SEP 7 1966 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | |

12116

CERTIFICATE OF DEATH

12116

Wife

Wife

Wife

(Wife)

(Wife)

(Wife)

Wife

Wife

Wife

Wife

Wife

Wife

Wife

Wife

Wife

Wife

Wife

Wife

Wife

(Wife)

(Wife)

Wife

Wife

Wife

Wife

12122

CERTIFICATE OF DEATH

12117

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
RAWLINGS 81-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
SACRED HEART HOSPITAL | | d. STREET ADDRESS
R.T.# 3 BOX 179 | |
| 3. NAME OF DECEASED (Type or print)
First HENRY Middle ARNOLD Last LEASE | | 4. DATE OF DEATH
Month SEPTEMBER Day 26 Year 1966 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11-7-95 |
| 9. AGE (In years last birthday) yrs. 70 | | 10. IF UNDER 1 YEAR
Months 0 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Crane Operator | | 10b. KIND OF BUSINESS OR INDUSTRY
Textile Plant | |
| 11. BIRTHPLACE (County & State, or foreign country)
W.VA. Fort Ashby | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
GARRETT LEASE (D) | | 14. MOTHER'S MAIDEN NAME
ELLEN LEASE (D) | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No. | | 16. SOCIAL SECURITY NO.
214-07-6997 | |
| 17. INFORMANT
Mrs. Pearl V. Lease Rawlings, Md. | | Address
PT'S CHART | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) Hypertensive Cardiovascular Disease
DUE TO
(c) Diabetes mellitus | | | INTERVAL BETWEEN ONSET AND DEATH
6 days
20 yr.
15 yr. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Generalized arteriosclerosis and osteoarthritis | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
None | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from March 31, 1952 , to Sept. 26, 1966 , that (I) (we) last saw the deceased alive on Sept. 26, 1956 , and that death occurred at 6:20 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
James P. Hallinan M.D. | | 22b. DATE SIGNED
9-27-66 | |
| 22c. PHYSICIAN'S NAME (Type)
DR. HALLINAN, M.D. | | 22d. ADDRESS
1140 BEDFORD ST. CUMBERLAND MARYLAND. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
9/29/66 | 23c. NAME OF CEMETERY OR CREMATORY
Mineral Chapel Baptist Cem. Nr. Ft. Ashby, Mineral, W.Va. | 23d. LOCATION (City or Town) (County) (State) |
| 24. FUNERAL DIRECTOR
H. Wayne George Cumberland, Md. | | 25a. REC'D BY REGISTRAR
DATE OCT 3 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13113

UNIT OF 100

13113

1-1-1

13113

13113

13113

13113

FOR STATE
HEALTH DEPT.

12122

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12118

| | | | |
|---|------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Allegany | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Md.
b. COUNTY
Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Gilmore | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frostburg | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Route #36 | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Samuel M. Leptic | | 4. DATE OF DEATH
Month Day Year
Sept. 4 1966 | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
July 1 1937 |
| 9. AGE (In years last birthday)
29 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Service Dept. Celanese Fibres | | 10b. KIND OF BUSINESS OR INDUSTRY
Frostburg | |
| 11. BIRTHPLACE (State or foreign country)
U. S. A. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Samuel Leptic | | 14. MOTHER'S MAIDEN NAME
Helen Brown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes World War 2 | | 16. SOCIAL SECURITY NO.
215-34-4340 | |
| 17. INFORMANT
Mrs. Don Adams | | Address
137 Water St. Frostburg Md | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
Shock
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
Fractured neck; Ruptured Liver
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
Minutes | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.
Driver of auto in one car accident | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m.
5:10 Sept. 4 1966 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Route # 36 | | 20f. (City or town) (County) (State)
Gilmore, Allegany, Maryland | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Benedict Skitarelic | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type)
BENEDICT SKITARELIC, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22. DATE SIGNED
September 4, 1966 | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| Address (Street, city, town, or county)
Cumberland, Maryland | | 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | |
| 23b. DATE THEREOF
Sept. 7 1966 | | 23c. NAME OF CEMETERY OR CREMATORY
Sunset Memorial Pk. | |
| 23d. LOCATION (City or Town) (County) (State)
Cumberland Allegany Md. | | 24. FUNERAL DIRECTOR
Hafer Funeral Home Frostburg, Md | |
| 25a. REC'D BY REGISTRAR
SEP 8 1966 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Use pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RESULTS

1994

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12119

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FROSTBURG | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FROSTBURG | |
| c. LENGTH OF STAY IN lb
LIFE | | d. STREET ADDRESS
131 BOWERY STREET | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
131 BOWERY STREET | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
HAROLD M. LEWIS | | 4. DATE OF DEATH
Month Day Year
SEPTEMBER 5, 19 66 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
FEB. 5, 1917 |
| 9. AGE (In years last birthday)
49 yrs. | | 10. IF UNDER 1 YEAR
Months Days
19 66 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
SHIPPING DEPT. | | 10b. KIND OF BUSINESS OR INDUSTRY
UNION CARBIDE | |
| 11. BIRTHPLACE (State or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JOHN E. LEWIS | | 14. MOTHER'S MAIDEN NAME
BESSIE MORGAN | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WW 2 | | 16. SOCIAL SECURITY NO.
217-10-5002 | |
| 17. INFORMANT
RICHARD LEWIS, ROCKVILLE, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gunshot of Head
DUE TO (b) (self inflicted)
DUE TO (c) (self inflicted) | | INTERVAL BETWEEN ONSET AND DEATH
Sudden | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Benedict Skitarelic
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D. | | 22. DATE SIGNED
September 5, 1966
Address (Street, city, town, or county) Cumberland, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
SEPT. 8, 1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY
FB'G. MEMORIAL PARK | | 23d. LOCATION (City or Town) (County) (State)
FROSTBURG, MD. | |
| 24. FUNERAL DIRECTOR
JOSEPH R. DURST, SR., FROSTBURG, MD. | | 25a. RECD BY REGISTRAR
SEP 8 1966 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15111

15111

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X

X

X

X

X September 5, 1960
Washington, D.C.

John F. Kennedy, Jr.

John F. Kennedy, Jr.

John F. Kennedy, Jr.

12125

CERTIFICATE OF DEATH

12120

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FROSTBURG | | c. LENGTH OF STAY IN 1b
15 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
MINERS HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First CLARENCE Middle L. Last LONG | | 4. DATE OF DEATH
Month SEPT. Day 13, Year 19 66 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
OCT. 27, 1883 |
| 9. AGE (In years last birthday)
82 yrs. | | 10. BIRTHPLACE (County & State, or foreign country)
PENNSYLVANIA | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MERCHANT | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
HENRY LONG | | 14. MOTHER'S MAIDEN NAME
ISABELLA BOUCHER | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16. SOCIAL SECURITY NO.
214-32-3019 | |
| 17. INFORMANT
MRS. GRACE P. LONG, FROSTBURG, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Perforated Gastric Ulcer.
DUE TO (b) Peritonitis.
DUE TO (c) 5401
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Aug 27, 1966 to Sept 13, 1966 , that (I) (we) lost saw the deceased alive on Sept 12, 1966 , and that death occurred at 11:00 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
S. E. ENFIELD | | 22b. DATE SIGNED
Sept 15 1966 | |
| 22c. PHYSICIAN'S NAME (Type)
S. E. ENFIELD, M. D. | | 22d. ADDRESS
ELLERSLIE, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
SEPT. 16, 1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY
FROSTBURG MEMORIAL PARK | | 23d. LOCATION (City or Town) (County) (State)
FROSTBURG, MD. | |
| 24. FUNERAL DIRECTOR
JOSEPH R. DURST, SR., FROSTBURG, MD. | | 25a. REC'D BY REGISTRAR
SEP 19 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE
<i>Charles J. Judge</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal in any event, within 72 hours after death.

15130

UNITED STATES OF AMERICA

15130

15130

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, within any event within 72 hours after death.

12126

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12121

| | | | | | |
|--|-------------------------------------|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. LENGTH OF STAY IN lb
30 Years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
208 Union Street | | | d. STREET ADDRESS
208 Union Street | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First Vincent Middle Paul Last Long | | | 4. DATE OF DEATH
Month September Day 22 Year 1966 | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 31, 1889 | 9. AGE (In years lost birthday)
77 yrs. | IF UNDER 1 YEAR
Months 19 Days 66 Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Employee-Celanese Corp of America | | 10b. KIND OF BUSINESS OR INDUSTRY
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
Corp | |
| 13. FATHER'S NAME
Nelson Long | | | 14. MOTHER'S MAIDEN NAME
Mary E. Cahill | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
217- 10-4974 | | 17. INFORMANT
Edgar Bucy | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) Coronary Sclerosis
DUE TO
(c) | | | | | INTERVAL BETWEEN ONSET AND DEATH
Sudden |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
<i>Benedict Skitarelic</i> | | M.D.
BENEDICT SKITARELIC, M.D. | | 22. DATE SIGNED
September 22, 1966 | |
| EXAMINER'S NAME (Type) | | ADDRESS
Cumberland Maryland 21502 | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Address (Street, city, town, or county) Cumberland, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
9/24/66 | 23c. NAME OF CEMETERY OR CREMATORY
S.S. Peter & Paul Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Cumberland Allegany Maryland | |
| 24. FUNERAL DIRECTOR
H. Lee Silcox | | ADDRESS
Cumberland Maryland 21502 | | 25a. REC'D BY REGISTRAR
DATE SEP 26 1966 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

15151

22151

12127

CERTIFICATE OF DEATH

12122

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY
ALLEGANY
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. LENGTH OF STAY IN lb
34 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
MEMORIAL HOSPITAL | | d. STREET ADDRESS
1401 OLDTOWN ROAD | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
ELWOOD Ellsworth LONGERBEAM | | 4. DATE OF DEATH
Month Day Year
SEPT. 26 1966 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
AUG. 28, 1906 |
| 9. AGE (In years last birthday)
60 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Mechanic | | 10b. KIND OF BUSINESS OR INDUSTRY
Railroad | |
| 11. BIRTHPLACE (County & State, or foreign country)
HARPERS FERRY, W. VA. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
GEORGE W. LONGERBEAM | | 14. MOTHER'S MAIDEN NAME
MARY PAINTER | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
MEMORIAL HOSPITAL, CUMBERLAND, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Tuber Disease + Ater. f. s.
DUE TO (b) Gastro Intestinal Hemorrhage, massive
DUE TO (c) Duodenal Ulcer. | | | INTERVAL BETWEEN ONSET AND DEATH
Days
Weeks. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State)
Cum. Alleg. Md. |
| 21. I certify that (I) (this hospital) attended the deceased from 9/26/66 , 19__, to 9/26/66 , 19__, that (I) (we) last saw the deceased alive on 9/26/66 , 19__, and that death occurred at 5:22 P. M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
R. D. Williams | | 22b. DATE SIGNED
9/28/66 | |
| 22c. PHYSICIAN'S NAME (Type)
R. D. Williams | | 22d. ADDRESS
Cumberland, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
Sept. 29, 1966 | 23c. NAME OF CEMETERY OR CREMATORY
Hillcrest Burial Park | 23d. LOCATION (City or Town) (County) (State)
Cumberland, Md. Allegany |
| 24. FUNERAL DIRECTOR
James F. Scarpelli, Cumberland, Md. | | 25a. REC'D BY REGISTRAR
Charles Judge | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | DATE
OCT 3 1966 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach a carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2000

\$151

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

| MARYLAND STATE DEPARTMENT OF HEALTH | | | |
|--|----------------------------------|---|------------------------------------|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
| 12128 | | 12123 | |
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | |
| a. COUNTY ALLEGANY
MARYLAND | | a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | |
| c. LENGTH OF STAY in lb
2 DAYS | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
MEMORIAL | | d. STREET ADDRESS
125 INDEPENDENCE ST. | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
MR. MELVIN C. LOVE | | 4. DATE OF DEATH
Month SEPT. Day 13 Year 1966 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4/12/18 |
| 9. AGE (In years last birthday)
48 yrs. | | 10. IF UNDER 1 YEAR
Months 1 Days 19 Hours 66 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
BUS DRIVER | | 10b. KIND OF BUSINESS OR INDUSTRY
CITY BUS LINE | |
| 11. BIRTHPLACE (County & State, or foreign country)
PITTSBURGH, PA. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
CLYDE LOVE | | 14. MOTHER'S MAIDEN NAME
MARGARET KING | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
220 10 6699 | |
| 17. INFORMANT
MEMORIAL HOSPITAL, CUMBERLAND, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 7545 Congestive Heart Failure, probably with terminal pulmonary embolus
DUE TO (b) Congenital Heart Disease, specifically infundibular stenosis, with pulmonic hypertension and cor pulmonale
DUE TO (c) Polycythemia, presumed secondary to heart disease and hypoxemia | | | |
| INTERVAL BETWEEN ONSET AND DEATH
5 months | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Polycythemia, presumed secondary to heart disease and hypoxemia | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from March 20, 1959 , to Sept. 12th, 1966 , that (I) (we) last saw the deceased alive on Sept. 12th, 1966 and that death occurred at 3:39 AM from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Wyand R. Doerner, Jr. | | 22b. DATE SIGNED
9-14-66 | |
| 22c. PHYSICIAN'S NAME (Type)
DR. WYAND DOERNER, Jr. | | 22d. ADDRESS
412 N. MECHANIC ST. CUMBERLAND MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
SEPT. 15, 1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY
HILLCREST BURIAL PARK | | 23d. LOCATION (City or Town) (County) (State)
CUMBERLAND, MD. | |
| 24. FUNERAL DIRECTOR
BYRON KIGHT | | 25a. REC'D BY REGISTRAR
SEP 16 1966 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

13138

13138

CERTIFICATE OF DEATH

J. D. WARD

CHIEF OF POLICE

2 DAY

RECEIVED

12-11-04

C. LOVE

INTERVIEW

WHITE

WHITE

CHIEF OF POLICE

CLYDE

CHIEF OF POLICE

12-11-04

History of a heart failure, probably with left-ventricular hypertrophy, especially in the left ventricle, with pulmonary hypertension and cor pulmonale.

History of a heart failure, probably with left-ventricular hypertrophy, especially in the left ventricle, with pulmonary hypertension and cor pulmonale.

12-11-04

12-11-04

12-11-04

12-11-04

12-11-04

12-11-04

12-11-04

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12129

12124

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|----------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. LENGTH OF STAY IN lb
20 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
MEMORIAL HOSPITAL | | d. STREET ADDRESS
509 EASTERN AVENUE | |
| 3. NAME OF DECEASED (Type or print)
First ANTHONY Middle A Last LOWERY | | 4. DATE OF DEATH
Month SEPT Day 17 Year 19 66 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10-14-1877 |
| 9. AGE (In years la 88 thday) yrs.
88 | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Employee of Baking Company | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
PENNA. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
ANTHONY LOWERY | | 14. MOTHER'S MAIDEN NAME
MARY BAKER | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
212-24-0681 | |
| 17. INFORMANT
MEMORIAL HOSPITAL, CUMBERLAND, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Congestive Heart Failure
DUE TO (b) Qual arteriosclerosis
DUE TO (c) 4500
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
4500 | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 8:30 , 19 66 , to 9:17 , 19 66 , that (I) (we) last saw the deceased alive on 9-17 , 19 66 , and that death occurred at 2:30 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
William P. James | | 22b. DATE SIGNED
9/19/66 | |
| 22c. PHYSICIAN'S NAME (Type)
DR. W P JAMES | | 22d. ADDRESS
441 N CENTRE ST. CUMBERLAND, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
9/20/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Bethel Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Centerville Bedford Penna | |
| 24. FUNERAL DIRECTOR
H. Lee Silcox | | 25a. REC'D BY REGISTRAR
SEP 22 1966 | |
| ADDRESS
Cumberland Maryland 21502 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | |

13134

13134

ALLEGANY

CLIFFLAND

CLIFFLAND

CLIFFLAND

MEMORIAL HOSPITAL

507 EASTERN AVENUE

ANTHONY

LOWERY

SEPT

19 1900

MALE WHITE

10-14-1877

PEPPER

L.C.A.

LOWERY

JACK BAKER

HOSPITAL, CLIFFLAND, W.V.

DR. W. P. JAMES

DR. H. CENTRE ST. CLIFFLAND, W.V.

12130

CERTIFICATE OF DEATH

13567

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. LENGTH OF STAY IN lb
15 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
MEMORIAL HOSPITAL | | e. STREET ADDRESS
404 BEALL ST., | |
| 3. NAME OF DECEASED (Type or print)
First AGNES Middle MCKINNEY Last MCKINNEY | | 4. DATE OF DEATH
Month SEPT. Day 28 Year 1966 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9-2-1891 |
| 9. AGE (In years last birthday)
75 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 11. BIRTHPLACE (County & State, or foreign country)
MARYLAND Lonaconing | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
HUGH MCMILLAN | | 14. MOTHER'S MAIDEN NAME
JENNIE E. SHOCKLEY | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
MEMORIAL HOSPITAL, CUMBERLAND, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia
DUE TO Congestion of lungs
(b) Renal failure due to Pyloroplasty + nephrosclerosis
DUE TO underlying
(c) 15 days
15 days
15 days | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Tuberculosis L.C., post op to possible pneumonia | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH
15 days | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Sept 13, 1966 to Sept 28, 1966 , that (I) (we) last saw the deceased alive on Sept 28, 1966 , and that death occurred at 6:45 PM from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Charles Judge | | 22b. DATE SIGNED
10/1/66 | |
| 22c. PHYSICIAN'S NAME (Type)
DR. S. G. WEISMAN | | 22d. ADDRESS
59 GREENE ST. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
October 1, 1966 | 23c. NAME OF CEMETERY OR CREMATORY
Davis Memorial Cem. | 23d. LOCATION (City or Town) (County) (State)
Cumberland, Md. Allegany |
| 24. FUNERAL DIRECTOR
James F. Scarpelli, Cumberland, Md. | | 25a. REC'D BY REGISTRAR
DATE OCT 10 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13130

CLARK OF BIRM

13204

WILEY

WILEY

CUTLER

CUTLER

MEMORIAL HOSPITAL

MEMORIAL HOSPITAL

WILEY

WILEY

WILEY

WILEY

WILEY

WILEY

WILEY

WILEY

12131

CERTIFICATE OF DEATH

13549

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
o. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. LENGTH OF STAY IN 1b
2 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
MEMORIAL HOSPITAL | | d. STREET ADDRESS
309 OLDTOWN RD. | |
| 3. NAME OF DECEASED (Type or print)
First MARY Middle L. (Lee) Last METZ | | 4. DATE OF DEATH
Month SEPT. Day 30 Year 1966 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10-22-1940 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Art Teacher | | 10b. KIND OF BUSINESS OR INDUSTRY
Public School | 9. AGE (In years last birthday)
25 yrs. |
| 11. BIRTHPLACE (County & State, or foreign country)
CUMBERLAND, MD. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
CHARLES D. CALLIS | | 14. MOTHER'S MAIDEN NAME
FRANCES L. DOWLING | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
MEMORIAL HOSPITAL, CUMBERLAND, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ventricular fibrillation
DUE TO Phenobarbital - Bilateral
(b) Cerebral infarction
DUE TO Cerebral infarction
(c) Cerebral infarction | | | INTERVAL BETWEEN ONSET AND DEATH
N.K. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from March 1966 to 7/30 , 19 66 that (I) (we) last saw the deceased alive on 7/30 19 66 , and that death occurred at 9:17 PM from causes and on the date stated above. | | | |
| 22a. SIGNATURE
DR. L. L. MOULD | | 22b. DATE SIGNED
9/1/66 | |
| 22c. PHYSICIAN'S NAME (Type)
DR. L. L. MOULD | | 22d. ADDRESS
1068 NATIONAL HIGHWAY | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
Oct. 3, 1966 | 23c. NAME OF CEMETERY OR CREMATORY
Hillcrest Burial Park | 23d. LOCATION (City or Town) (County) (State)
Cumberland, Md. Allegany |
| 24. FUNERAL DIRECTOR
James F. Scarpelli, Cumberland, Md. | | 25a. REC'D BY REGISTRAR
OCT 10 1966 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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12131

CERTIFICATE OF DEATH

12131

ALLIANCE

ALLIANCE

ALLIANCE

CUMBERLAND

2 DAYS

CUMBERLAND

MEMORIAL HOSPITAL

209 OLIVER RD.

WAS

L.

WET

SEP.

60 60

FEMALE WHITE

11-22-1940

CUMBERLAND, MD.

CHARLES D. GALL

FRANCIS J. BOLING

MEMORIAL HOSPITAL, CUMBERLAND, MD.

1000 NATIONAL HIGHWAY

DR. L. L. WOLF

1000 NATIONAL HIGHWAY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | |
|--|--|---|---|--|---|--|---|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | |
| 12132 Item #7 Film #0351 10/6/66 pg | | | | | | | | | | | | | | |
| 12125 | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | | | | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | | | | | | | |
| c. LENGTH OF STAY IN 1b
40 YEARS | | | | | d. STREET ADDRESS
211 FULTON STREET | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
211 FULTON STREET | | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First RUTH Middle B. Last MILLER | | | 4. DATE OF DEATH
Month SEPT. Day 30 Year 19 66 | | | | | | | | | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH
SEPT. 9, 1891 | | 9. AGE (In years last birthday)
75 yrs. | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | | 10b. KIND OF BUSINESS OR INDUSTRY
OWNNHOME | | 11. BIRTHPLACE (County & State, or foreign country)
MARYLAND | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | | | | |
| 13. FATHER'S NAME
HORACE G. BUCHANAN | | | | | 14. MOTHER'S MAIDEN NAME
DELILAH DeVORE | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
NO | | | 16. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
GRACE WELTMAN | | | Address
ELLERSLIE, MD. | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute Coronary Thrombosis</i>
4201 DUE TO (b) <i>myocarditis & Decompensation</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>July 20, 1966</i> to <i>Sept 30, 1966</i> , that (I) (we) last saw the deceased alive on <i>Sept 26, 1966</i> , and that death occurred at <i>8 AM</i> , from the causes and on the date stated above. | | | | | | | | | | | | | | |
| 22a. SIGNATURE
<i>Clay E. Durrett</i> | | | | | 22b. DATE SIGNED
SEPT. 30, 1966 | | 22c. PHYSICIAN'S NAME (Type)
CLAY E. DURRETT, M.D. | | | | | | | |
| 22d. ADDRESS
236 MARYLAND AVE. CUMBERLAND, MD. | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | 23b. DATE THEREOF
OCT. 2, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY
COOKS MILLS CEMETERY | | | 23d. LOCATION (City, town or county) (State)
ELLERSLIE, MD. | | | | | | |
| 24. FUNERAL DIRECTOR
BYRON KIGHT | | | | | 25a. REC'D BY REGISTRAR
OCT 3 1966 | | | | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | | |

15131

15131

15131

12138

CERTIFICATE OF DEATH

12126

| | | | |
|--|----------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frostburg
c. LENGTH OF STAY IN 1b
1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Miners Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lonaconing
d. STREET ADDRESS
8 Furnace Street
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
JOSEPH H. MORTON | | 4. DATE OF DEATH
Month 9 Day 15 Year 1966 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10/28/1889 |
| 9. AGE (In years last birthday)
76 yrs. | | 10. IF UNDER 1 YEAR
Months 0 Days 1 Hours 1 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired-Celaneese Employee | | 10b. KIND OF BUSINESS OR INDUSTRY
INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Lonaconing, MD. | | 12. CITIZEN OF WHAT COUNTRY?
USA. | |
| 13. FATHER'S NAME
John Morton | | 14. MOTHER'S MAIDEN NAME
Elizabeth Crosser | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
217-10-5641 | |
| 17. INFORMANT
A. Mrs. Jean Steele | | Address
Lonaconing, MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Congestive Heart failure
442X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic Cardiovascular senoldies
DUE TO
(c) gors- | | INTERVAL BETWEEN ONSET AND DEATH
4 months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from June , 19 66 , to Sept. 15 , 19 66 that (I) (we) last saw the deceased alive on Sept 15 , 19 66 , and that death occurred at 9:30 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
John B. Davis | | 22b. DATE SIGNED
9/16/66 | |
| 22c. PHYSICIAN'S NAME (Type)
John B. DAVIS, M.D. | | 22d. ADDRESS
Frostburg, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
9/18/1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Oak Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Lonaconing, MD. | |
| 24. FUNERAL DIRECTOR
GEORGE EICHHORN | | 25a. REC'D BY REGISTRAR
Lonaconing, MD. | |
| 25b. REGISTRAR'S SIGNATURE
SEP 12 1966 | | 25c. REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

35104

96151

12134

CERTIFICATE OF DEATH

12127

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Barton | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First David Middle E. Last Moses | | 4. DATE OF DEATH
Month September Day 20 Year 1966 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2/12/1899 |
| 9. AGE (In years last birthday)
67 yrs. | | IF UNDER 1 YEAR
Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Auto Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY
Morton Garage | |
| 11. BIRTHPLACE (County & State, or foreign country)
Lonaconing, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
James Moses | | 14. MOTHER'S MAIDEN NAME
Agnes McNeil | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Mrs. Felicit Moses | | Address
Barton, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Ischemia
DUE TO ACVD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) years
DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Pulmonary Fibrosis Emphysema | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Sept 20, 1966 , to Sept 20, 1966 , that (I) (we) last saw the deceased alive on Sept 20, 1966 , and that death occurred at 11 p.m. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
L.R. Miles JR MD | | 22b. DATE SIGNED
9-22-66 | |
| 22c. PHYSICIAN'S NAME (Type)
L.R. MILES JR MD | | 22d. ADDRESS
LONA CONING MD | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
9/23/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Laurel Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Moscow, A. Md. | |
| 24. FUNERAL DIRECTOR
George Eichhorn | | 25a. REC'D BY REGISTRAR
SEP 26 1966 | |
| ADDRESS
Lonaconing, Md. | | 25b. REGISTRAR'S SIGNATURE
J Charles Judge | |

7252

05181

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12135

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12128

| | | | |
|--|----------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Frostburg, MD. (Shaft Rural) | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Memorial Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First CANDACE Middle MYERS Last MYERS | | 4. DATE OF DEATH
Month 9/12/1966 Day 19 Year 19 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10/3/1869 |
| 9. AGE (In years last birthday)
96 yrs. | | 10. IF UNDER 1 YEAR
Months 0 Days 0 Hours 0 Min. 0 | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 12. CITIZEN OF WHAT COUNTRY?
USA. | |
| 13. FATHER'S NAME
Nelson Meese | | 14. MOTHER'S MAIDEN NAME
Mary Sigler | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Mrs. Ada Philpot | | Address
Shaft, MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Myocarditis
4221 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Arteriosclerotic Cardiovascular disease --
(c) Fracture of Left Hip, Terminal Pneumonia | | INTERVAL BETWEEN ONSET AND DEATH
Months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Fracture of Left Hip, Terminal Pneumonia | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 5:00 AM m. July 31 19 66 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Sylvan Retreat | | 20f. (City or town) (County) (State)
Cumberland, Alleg. Md. | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Benedict Skitarelic M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Benedict Skitarelic, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22. DATE SIGNED
Sept. 12, 1966 | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
9/14/1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Laurel Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Moscow, MD. | |
| 24. FUNERAL DIRECTOR
GEORGE EICHHORN | | ADDRESS
Lonaconing, MD. | |
| 25a. REC'D BY REGISTRAR
SEP 14 1966 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

3512

REFL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|---|---|---|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| Items #14 & 17 Film #G381 10/3/66 pc | | | | | | | | | |
| 12136 | | | | | | | | | |
| 12124 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | | c. LENGTH OF STAY IN 1b
Years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Sacred Heart Hospital | | | | | d. STREET ADDRESS
224 Glenn St. | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
Samuel Russell Nave | | | | | 4. DATE OF DEATH
Month 9 Day 23 Year 1966 | | | | |
| 5. SEX
M | | 6. COLOR OR RACE
W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
8/22/00 | | 9. AGE (In years last birthday) yrs. 66 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Cook | | | 10b. KIND OF BUSINESS OR INDUSTRY
Restaurant | | 11. BIRTHPLACE (County & State, or foreign country)
Bedford Co., Penna. | | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Samuel Nave | | | | | 14. MOTHER'S MAIDEN NAME
Anna Tewell Carr | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | | 16. SOCIAL SECURITY NO.
214-07-3076 | | 17. INFORMANT
Mrs. Edith Nave Carr
Address 224 Glenn St Cumberland, Md
patient's chart | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Pulmonary Edema
DUE TO
(b) Arteriosclerotic Cardiovascular Disease
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan , 19 64 to Sept 23 19 66 , and that death occurred at 5 A.M. , from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
W C Spiggle | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22b. DATE SIGNED
Sept 25, 1966 | |
| 22c. PHYSICIAN'S NAME (Type)
W C Spiggle | | | | | 22d. ADDRESS
126 N. Smallwood St Cumberland, Md | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Sept 26, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY
Sunset Memorial Gardens | | 23d. LOCATION (City or Town) (County) (State)
Near Cumberland Allegany, Md. | | | |
| 24. FUNERAL DIRECTOR
John J. Hafer, Jr. | | | | | 25a. REC'D BY REGISTRAR
SEP 27 1966 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

45151

96151

CERTIFICATE OF DEATH

12137

12130

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frostburg
c. LENGTH OF STAY IN b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Miners Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE Maryland
b. COUNTY Allegany
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lonaconing
d. STREET ADDRESS Advocate Court
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First ELIZABETH Middle OLEWINE Last
4. DATE OF DEATH
Month 9 Day 11 Year 1966 | | 5. SEX Female
6. COLOR OR RACE White
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH
JAN, 1876
9. AGE (In years last birthday) 90 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Saleslady
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country) Lonaconing
12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Joseph Jones
14. MOTHER'S MAIDEN NAME Elizabeth Fatkins | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
16. SOCIAL SECURITY NO.
17. INFORMANT Address JEANETTE JOHNSON, Rockville, MD. | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myocardial ischemia
4201 DUE TO Congestive failure
(b) ACVD
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from Sept 10 1966 to Sept 11, 1966 that (I) (we) last saw the deceased alive on Sept 10 1966 , and that death occurred at 3 A.M. from the causes and on the date stated above. | |
| 22a. SIGNATURE L R MILES JR
22c. PHYSICIAN'S NAME (Type) L R MILES JR | | 22b. DATE SIGNED 9-12-66
22d. ADDRESS Lonaconing MD | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 9/13/1966
23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery
23d. LOCATION (City, town or county) (State) Lonaconing, MD. | | 24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS GEORGE EICHHORN Lonaconing, MD.
25a. REC'D BY REGISTRAR DATE SEP 13 1966
25b. REGISTRAR'S SIGNATURE Charles Judge | |

MEDICAL CERTIFICATION

12130

COMMUNICATIONS OF DEATH

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CERTIFICATE OF DEATH

12131

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. LENGTH OF STAY IN 1b
16 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
MEMORIAL HOSPITAL | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First ORPHA Middle PATTON Last PATTON | | 4. DATE OF DEATH
Month SEPT Day 17 Year 19 66 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5-11-88 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 11. BIRTHPLACE (County & State, or foreign country)
GARRETT CO, MARYLAND | |
| 13. FATHER'S NAME
Mahlon MILLER | | 14. MOTHER'S MAIDEN NAME
ANNA FULLER Eichorn | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
MEMORIAL HOSPITAL, CUMBERLAND, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Abdominal Carcinoma
DUE TO (b) Lesion in Colon
DUE TO (c) —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH
2 weeks |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. — p.m. — 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State)
Cumbrld, Allegany Md |
| 21. I certify that (I) (this hospital) attended the deceased from 4/22/66 , 19 — , to 9/17/66 , 19 — , that (I) (was) lost saw the deceased alive on 9/17/66 , 19 — , and that death occurred at 3:35 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
R. J. Williams M.D. | | 22b. DATE SIGNED
9/17/66 | |
| 22c. PHYSICIAN'S NAME (Type)
DR. R. J. WILLIAMS | | 22d. ADDRESS
122 S CENTRE ST. CUMBERLAND, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
9/20/66 | 23c. NAME OF CEMETERY OR CREMATORY
Grantsville Cem. | 23d. LOCATION (City or Town) (County) (State)
Grantsville Garrett, Md. |
| 24. FUNERAL DIRECTOR
Don Newman | | 25a. REC'D BY REGISTRAR
SEP 26 1966 | |
| ADDRESS
Grantsville, Md. | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12131

NEW BRIDGE OF DEATH

12131

ALL ECHAM

WAB LANE

ALBANY

CUMBERLAND

10 DAYS

CUMBERLAND

503 EICHNER AVE.

MEMORIAL HOSPITAL

DEATH

POTCH

DEPT

EMALE WHITE

1911-12

CAPRETTA, HARRY AND

EMALE WHITE

WILLIAM LUCAS

THE MEMORIAL HOSPITAL, CUMBERLAND, MD.

ACTUAL TIME

1911-12

DR. W. J. WILLIAMS

122 S. CENTRE ST. CUMBERLAND, MD.

12139

CERTIFICATE OF DEATH

12139

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland Rt #1 Bx 503 | | c. LENGTH OF STAY IN 1b
4 Years | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS
Cumberland Rt #1 Box 503 | |
| 3. NAME OF DECEASED (Type or print)
First Ada Middle Belle Last Phillips | | 4. DATE OF DEATH
Month September Day 21 Year 1966 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Jan 11, 1900 |
| 9. AGE (In years last birthday)
66 yrs. | | 10. IF UNDER 1 YEAR
Months 2 Days 19 Hours 66 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housekeeper | | 10b. KIND OF BUSINESS OR INDUSTRY
At Home | |
| 11. BIRTHPLACE (County & State, or foreign country)
Chaneyville, Penna | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Leonadus Pardew | | 14. MOTHER'S MAIDEN NAME
Mary Hamilton | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
161-32-9679 | |
| 17. INFORMANT
Leslie C. Phillips | | Address Rt #1 Box 503 Cumberland, Md | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic carcinoma, gen'l
DUE TO (b) Adeno Ca of breast
DUE TO (c) 170X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH
2-3 yrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Aug 20, 1966 to Sept 24, 1966 that (I) (we) last saw the deceased alive on Aug 20, 1966 , and that death occurred at 1:00 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Dr. A. J. Mirk in | | 22b. DATE SIGNED
9-24-66 | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. A. J. Mirk in | | 22d. ADDRESS
115 So. Centre St - Cumberland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
9/26/66 | 23c. NAME OF CEMETERY OR CREMATORY
Chaneyville Cemetery | 23d. LOCATION (City or Town) (County) (State)
Chaneyville Bedford Penna |
| 24. FUNERAL DIRECTOR
H. Lee Silcox | | 25a. REC'D BY REGISTRAR
SEP 27 1966 | |
| ADDRESS
Cumberland Maryland 21502 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

66121

15134

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and comply event within 72 hours after death.

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6M 1/66

12140

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12134

| | | | | | | | |
|---|----------------------------------|---|--|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. LENGTH OF STAY IN lb
Years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Memorial Hospital | | | | d. STREET ADDRESS
104 Park Street | | | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Willis C. Pollock | | | | 4. DATE OF DEATH
Month Day Year
Sept 17 1966 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
August 11, 1890 | | 9. AGE (In years last birthday)
76 yrs. | IF UNDER 1 YEAR
Months Days
IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Foreman | | 10b. KIND OF BUSINESS OR INDUSTRY
B & O RR | | 11. BIRTHPLACE (State or foreign country)
Penna. | | 12. CITIZEN OF WHAT COUNTRY?
U S A | |
| 13. FATHER'S NAME
Charles C. Pollock | | | | 14. MOTHER'S MAIDEN NAME
Stella Iva Steele | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
215-385-3398 | | 17. INFORMANT
Carroll Pollock Address 211 Griffith Drive Douglasville, Pa. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis, left
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Sclerosis, generalized
DUE TO
(c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Sudden
----- |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Myocardial Infarctions, old | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Benedict Skitarelic M.D. | | | | 22. DATE SIGNED
Sept. 18, 1966 | | | |
| EXAMINER'S NAME (Type) Benedict Skitarelic, M.D. | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Cumberland, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Sept 18, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY
Sunset Memorial Park | | 23d. LOCATION (City or Town) (County) (State)
Near Cumberland, Md. | |
| 24. FUNERAL DIRECTOR
John J. Hafer ADDRESS 230 Balto. Ave. Cumberland, Md. | | | | 25a. REC'D BY REGISTRAR
SEP 20 1966 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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FOR STATE
HEALTH DEPT.

12141

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12135

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|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Allegany</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Cumberland</u> | | c. LENGTH OF STAY IN lb
<u>60 years</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>D. O. A. Memorial Hospital</u> | | e. STREET ADDRESS
<u>1008 Ella Avenue</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Walter</u> Middle <u>Cornelius</u> Last <u>Price</u> | | 4. DATE OF DEATH
Month <u>Sept.</u> Day <u>8</u> Year <u>1966</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>July 31, 1897</u> |
| 9. AGE (In years last birthday) yrs.
<u>69</u> | | 10. IF UNDER 1 YEAR
Months <u>0</u> Days <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Railway Postal Clerk</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Government</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Sandy Hook, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Winfield S. Price</u> | | 14. MOTHER'S MAIDEN NAME
<u>Clara M. Downs</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>yes War I II Korean</u> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<u>Mr. William W. Price, Cumberland, Md. Son</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>
<u>4201</u> DUE TO <u>Coronary Sclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>-----</u>
(c) <u>-----</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>sudden</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22. DATE SIGNED <u>Sept. 8, 1966</u> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Charles Judge</u> | |
| Address (Street, city, town, or county) <u>Cumberland, M.D.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>Sept. 10, 1966</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Rose Hill Cemetery</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Cumberland, Md. Allegany</u> |
| 24. FUNERAL DIRECTOR
<u>James F. Scarpelli, Cumberland, Md.</u> | | ADDRESS | |
| 25a. REC'D BY REGISTRAR
DATE <u>SEP 13 1966</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

15120

15121

STATE 204
1920-1921

[Faint, mostly illegible text and markings, possibly a ledger or form, with some handwritten notes.]



FOR STATE
HEALTH DEPT.

is necessary. If any is necessary, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | 3. NAME OF DECEASED | | 4. DATE OF DEATH | | 5. SEX | | 6. COLOR OR RACE | |
| a. COUNTY Allegany | | a. STATE Maryland b. COUNTY Garrett | | First Middle Last | | Month Day Year | | Male | | White | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| Cumberland | | Kitzmiller | | Memorial Hospital | | 3rd Ave. | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| Track Foreman | | W.Md. Railroad | | Moore, Tucker Co. Va. | | U.S.A. | | Alfred Floyd Propst | | Mary Ellen Huffman | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | INTERVAL BETWEEN ONSET AND DEATH | |
| No | | 705-10-6050 | | Brooks E. Evans, Kitzmiller, Md. | | | | PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) | | Hours | |
| | | | | | | | | 451X DUE TO | | | |
| | | | | | | | | Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) | |
| | | | | | | | | Ruptured abdominal arteriosclerotic aneurysm | | Hours | |
| | | | | | | | | (c) | | | |
| | | | | | | | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | | | | | Coronary Sclerosis, Marked | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY | | 20d. INJURY OCCURRED | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| | | | | Month, Day, Year | | While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | |
| | | | | Hour a.m. p.m. | | | | | | | |
| | | | | 19 | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: | | Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | CHIEF MEDICAL EXAMINER | | ASSISTANT MEDICAL EXAMINER | | DATE SIGNED | | | |
| ACTUAL SIGNATURE | | Benedict Skitarelic, M.D. | | | | | | DEPUTY MEDICAL EXAMINER | | September 29, 1966 | |
| EXAMINER'S NAME (Type) | | Benedict Skitarelic, M.D. | | Address (Street, city, town, or county) | | Cumberland, Md. | | | | | |
| 22b. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or country) (State) | | | | | |
| Burial | | Oct. 2, 1966 | | Garrett Co. Memorial Gardens- Oakland, Md. | | | | | | | |
| 23. FUNERAL DIRECTOR | | ADDRESS | | 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | | | | | |
| Amy Mildred Sharpless | | Blaine, W. Va. | | OCT 3 1966 | | Charles Judge | | | | | |
| | | P.O. Kitzmiller, Md. | | | | | | | | | |

MEDICAL CERTIFICATION

18186

18186

18186

CERTIFICATE OF DEATH

12137

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FROSTBURG | | c. LENGTH OF STAY IN 1b
14 DAYS | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
LONACONING |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
MINERS HOSPITAL | | d. STREET ADDRESS
102 JACKSON STREET | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print) MARGARET E. RAVENSCROFT | | 4. DATE OF DEATH
Month SEPTEMBER Day 14 Year 1966 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
FEB. 1, 1913 |
| 9. AGE (In years last birthday) 51 yrs. | | 10. IF UNDER 1 YEAR
Months 51 Days 14 Hours 14 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
WAITRESS | | 10b. KIND OF BUSINESS OR INDUSTRY
RESTAURANT | 11. BIRTHPLACE (County & State, or foreign country)
MARYLAND |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
FRANK W. RALEY | |
| 14. MOTHER'S MAIDEN NAME
CLARA A. MILLER | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
220-16-6749 | |
| 16. SOCIAL SECURITY NO.
220-16-6749 | | 17. INFORMANT
HILLARY RAVENSCROFT, LONACONING, MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic myocardial failure
DUE TO
(b) Hypertensive heart disease
DUE TO
(c) Ischemic heart disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | INTERVAL BETWEEN ONSET AND DEATH
6 months |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Sept. 30 , 19 66 to Sept. 14 , 19 66 that (I) (we) last saw the deceased alive on Sept. 14 , 19 66 , and that death occurred at 10:50 P.M., from causes and on the date stated above. | | | |
| 22a. SIGNATURE
G. Paige Strong | | 22b. DATE SIGNED
9/15/66 | |
| 22c. PHYSICIAN'S NAME (Type)
A. P. STRONG, M. D. | | 22d. ADDRESS
E. MAIN ST., FROSTBURG, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
9-17-66 | 23c. NAME OF CEMETERY OR CREMATORY
FROSTBURG MEMORIAL PARK | 23d. LOCATION (City or Town) (County) (State)
FROSTBURG, MD. |
| 24. FUNERAL DIRECTOR
JOSEPH R. DURST, SR., FROSTBURG, MD. | | 25a. REC'D BY REGISTRAR
DATE SEP 19 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

76131

151

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12146

12138

| | | | |
|--|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland b. COUNTY
Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | |
| c. LENGTH OF STAY IN lb
4 days | | d. STREET ADDRESS
827 Mt. Royal Avenue | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Sacred Heart Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
Harry Francis Reinhart | | 4. DATE OF DEATH
Month 9 Day 20 Year 1966 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8/10/77 |
| 9. AGE (In years lost birthday)
89 yrs. | | 10. IF UNDER 1 YEAR
Months 11 Days 10 Hours 10 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Supervisor retired | | 10b. KIND OF BUSINESS OR INDUSTRY
Kelly Tire Plant | |
| 11. BIRTHPLACE (County & State, or foreign country)
Allegany Co., Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Francis Reinhart | | 14. MOTHER'S MAIDEN NAME
Mary A. Downey | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
215-12-7228-A | |
| 17. INFORMANT
patient's chart | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) congestive heart failure
DUE TO (b) myocardial infarction
DUE TO (c) arteriosclerosis
Subacute
INTERVAL BETWEEN ONSET AND DEATH
1 week
unknown | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Prostate hypertrophy | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 9/19, 1966 , to 9/20, 1966 , that (I) (we) last saw the deceased alive on 9/19, 1966 , and that death occurred at 9/20, 1966 , M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
S. G. Weisman | | 22b. DATE SIGNED
9/22/66 | |
| 22c. PHYSICIAN'S NAME (Type)
S. G. Weisman, M.D. | | 22d. ADDRESS
59 Greene St., Cumberland, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
9/22/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY
SS. Peter & Paul Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Cumberland, Allegany, Md. | |
| 24. FUNERAL DIRECTOR
H. Wayne George | | 25a. REC'D BY REGISTRAR
SEP 26 1966 | |
| 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12145

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12139

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
o. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. LENGTH OF STAY IN lb
DOA | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Sacred Heart Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Harry Middle N. Last Rice | | 4. DATE OF DEATH
Month 9 Day 27 Year 1966 | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
April 18, 1889 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Union Laundry Employee | | 10b. KIND OF BUSINESS OR INDUSTRY
Cumberland Maryland | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
John N. Rice | | 14. MOTHER'S MAIDEN NAME
Olive Francis North | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
214-05-7712A | |
| 17. INFORMANT
Mrs. Hazel K. Rice | | Address 318 Bedford St
Cumberland, Md | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Sclerosis
DUE TO
(c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH
Sudden
----- |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. _____ p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
9/30/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Rosehill Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Cumberland Allegany Maryland | |
| 24. FUNERAL DIRECTOR
Dale L. Merritt | | ADDRESS
Cumberland Maryland 21502 | |
| 25a. REC'D BY REGISTRAR
DATE SEP 29 1966 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

22. DATE SIGNED

September 27, 1966

Address (Street, city, town, or county) **Cumberland, Md.**

12130

12132

Germany, Berlin

Germany, Berlin

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Allegany</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>Allegany</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Rt. # 4 Cumberland.</i> | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<i>Brice Hollow Rd.</i> | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <i>Herbert</i> Middle <i>Wade</i> Last <i>Rice</i> | | 4. DATE OF DEATH
Month <i>Sept.</i> Day <i>5</i> Year <i>19 66</i> | |
| 5. SEX
<i>Male</i> | 6. COLOR OR RACE
<i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>June 30, 1894</i> |
| 9. AGE (In years last birthday)
<i>72</i> yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Ret. farmer</i> | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>Farm owner</i> | |
| 11. BIRTHPLACE (State or foreign country)
<i>Twiggstown, Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U. S. A.</i> | |
| 13. FATHER'S NAME
<i>Millard E. Rice</i> | | 14. MOTHER'S MAIDEN NAME
<i>Sarah V. Rice</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<i>No.</i> | | 16. SOCIAL SECURITY NO.
<i>220-34-1434</i> | |
| 17. INFORMANT
<i>Mrs. Ruth Rice</i> | | Address
<i>Rt. # 4 Cumberland, Md.</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i>
DUE TO (b) <i>Advanced Coronary Insufficiency</i>
DUE TO (c) <i>Generalized atherosclerosis</i>
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH
<i>sudden</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<i>Stokes-Adams Syndrome</i> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>7.3.</i> 19 <i>59</i> , to <i>9.5</i> 19 <i>66</i> , that I last saw the deceased alive on <i>8.31.66</i> , and that death occurred at <i>8:00 P.</i> M. from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) <i>441 N. Centre St</i> DATE SIGNED <i>9.6.66</i> | |
| ACTUAL SIGNATURE <i>William P. James</i> M.D. | | PHYSICIAN'S NAME (Type) <i>William P. James, M.D.</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 22b. DATE THEREOF
<i>9/8/66</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<i>Mount Pleasant Cemetery</i> | | 22d. LOCATION (City, town, or county) (State)
<i>Nr. Cumberland, Allegany Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>H. Wayne George</i> | | ADDRESS
<i>Cumberland, Maryland</i> | |
| 24a. REC'D BY REGISTRAR
DATE <i>SEP 9 1966</i> | | 24b. REGISTRAR'S SIGNATURE
<i>J. Charles Judge</i> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If the funeral director is not present, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|-------------------------------------|--|---|--|--|--|--|-------|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 12147 | | | | | | CERTIFICATE OF DEATH | | | 12141 | | |
| 1. PLACE OF DEATH
o. COUNTY Allegany MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE Maryland b. COUNTY Allegany | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | | | c. LENGTH OF STAY IN lb
8/13/1966 | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland 01-1 | | | | d. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Allegany County Infirmary | | | | | | d. STREET ADDRESS
Rt. #1, Valley Road | | | | | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
Sterling Ward Ryan | | | | | | 4. DATE OF DEATH Month Day Year
September 12, 19 66 | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
12/24/1885 | | 9. AGE (In years last birthday)
80 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired: Tire Worker | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Kelly Tire Plant | | 11. BIRTHPLACE (County & State, or foreign country)
West Virginia, St. George | | | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Daniel Webster Ryan | | | | | | 14. MOTHER'S MAIDEN NAME
Tabitha Hester Parsons | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
214-07-1145 | | 17. INFORMATION FROM DEATH RECORDS
Mrs. Delta Ryan Address Cumberland, Md. | | | | RD. #1 Valley Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ① Myocarditis, chr. degenerative
DUE TO (b) ② Arterio Sclerosis & Hypertension
(c) ③ Parkinson's Disease, severe
DUE TO (d) ④ Bilateral lobaritis
(e) ⑤ Ulceration of Bowels & Bile Ducts
4221
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 8/13/66 , 19__, to 9/12/66 , 19__, that (I) (we) lost saw the deceased alive on 9/10/66 , 19__, and that death occurred at A. M. , from causes on and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
Lee B. Mathews | | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
9/12/1966 | | | |
| 22c. PHYSICIAN'S NAME (Type)
Lee B. Mathews, M. D. | | | | | | 22d. ADDRESS
49 Greene St., Cumberland, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
9/15/66 | | 23c. NAME OF CEMETERY OR CREMATORY
Sunset Memorial Park | | | | 23d. LOCATION (City or Town) (County) (State)
Cumberland, Allegany Md. | | | |
| 24. FUNERAL DIRECTOR
H. Wayne George | | | | | | ADDRESS
Cumberland, Md. | | 25a. REC'D BY REGISTRAR
DATE SEP 16 1966 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | |

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
|---|--|----------------------------------|--|---|--|---|--|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FROSTBURG | | | | c. LENGTH OF STAY IN 1b
LIFE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FROSTBURG | | | | d. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
MINERS HOSPITAL | | | | | | d. STREET ADDRESS
196 W. MECHANIC ST. | | | | | |
| 3. NAME OF DECEASED (Type or print)
MARY | | | First K. Middle SATHOFF Last | | | 4. DATE OF DEATH
Month SEPT. Day 30, Year 19 66 | | | | | |
| 5. SEX
FEMALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
MAY 13, 1890 | | 9. AGE (In years last birthday)
76 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSE WORK | | | | 10b. KIND OF BUSINESS OR INDUSTRY
OWN HOME | | 11. BIRTHPLACE (State or foreign country)
MARYLAND | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
CONRAD BRODE | | | | | | 14. MOTHER'S MAIDEN NAME
RACHEL KIRKWOOD | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
217-28-7676 | | 17. INFORMANT
MRS. JOSEPH LEWIS, FROSTBURG, MD. | | | Address 39 W. FIRST ST., | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion

4201 DUE TO Coronary Sclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
Sudden

-- | |
| | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Benedict Skitarelic | | | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22. DATE SIGNED | | |
| EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M. D. | | | | | | Address (Street, city, town, or county) RD 1, CUMBERLAND, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | 23b. DATE THEREOF
OCT. 3, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY
FB'G. MEMORIAL PARK | | | 23d. LOCATION (City, town or county) (State)
FROSTBURG, MD. | | | |
| 24. FUNERAL DIRECTOR
JOSEPH R. DURST, SR., FROSTBURG, MD. | | | | | | 25a. REC'D BY REGISTRAR
DATE OCT 5 1966 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10/10/00 BY 1043

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10/10/00 BY 1043

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CERTIFICATE OF DEATH

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|--|----------------------------------|---|-----------------------------------|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Allegany | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland | | b. COUNTY
Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. LENGTH OF STAY IN 1b
56 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Sacred Heart Hospital | | | | d. STREET ADDRESS
429 Arch Street | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Mary Elizabeth Schultz | | | | 4. DATE OF DEATH
Month Day Year
September 17 19 66 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
5-4-10 | | 9. AGE (In years last birthday)
56 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (County & State, or foreign country)
Allegany, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
John Whitman (D) | | | | 14. MOTHER'S MAIDEN NAME
Kathern (Smit) Whitman (D) | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Unknown | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Patients Chart | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatous - OVARY
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
ABCESS OF FEMORAL CANAL | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 8-20, 19 66 , to 9-17, 19 66 , that (I) (we) last saw the deceased alive on 9-17, 19 66 , and that death occurred at 11 A.M. , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
[Signature] | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
9-20-66 | |
| 22c. PHYSICIAN'S NAME (Type)
L. MICHAEL GELICK | | | | 22d. ADDRESS
126 N. SMALLWOOD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Sept. 19, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Mary's Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Cumberland, Md. Allegany | |
| 24. FUNERAL DIRECTOR
James F. Scarpelli, Cumberland, Md. | | | | 25a. REC'D BY REGISTRAR
DATE SEP 26 1966 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

22154

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|----------------------------------|---|---|--|---|------------------------------------|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 12150 | | | | | 12144 | | | | |
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
LONA CONING | | | c. LENGTH OF STAY IN 1b
27 MONTHS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FROSTBURG | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
KYLE NURSING HOME | | | | | d. STREET ADDRESS | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
GEORGE W. SCHURG | | | 4. DATE OF DEATH
Month Day Year
SEPT. 15, 1966 | | | | | | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
OCT. 1, 1888 | | 9. AGE (In years last birthday)
77 yrs. | 10. IF UNDER 1 YEAR
Months Days | 11. IF UNDER 24 HRS.
Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
MINER | | | 10b. KIND OF BUSINESS OR INDUSTRY
COAL | | 11. BIRTHPLACE (County & State, or foreign country)
DEAL, PENNSYLVANIA | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 13. FATHER'S NAME
CARL SCHURG | | | 14. MOTHER'S MAIDEN NAME
JULIA DELBROOK | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) NO | | | 16. SOCIAL SECURITY NO.
216-90-6806 | | 17. INFORMANT
Address LA VALE, MD.
MR. HARRY SCHURG, 1231 NATIONAL HIGHWAY | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
493 x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Arteriosclerotic CVD disease & congestive failure | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 days | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 1964 , to Sept. 15, 1966 , that (I) (we) last saw the deceased alive on Sept. 14, 1966 , and that death occurred at M , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
Leslie R. Miles | | | M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
9-17-66 | | |
| 22c. PHYSICIAN'S NAME (Type)
LESLIE R. MILES, M.D. | | | 22d. ADDRESS
STATE ROAD, LONA CONING, MD. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | 23b. DATE THEREOF
SEPT. 18, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY
FROSTBURG MEM. PARK | | 23d. LOCATION (City, town or county) (State)
FROSTBURG, MARYLAND | | |
| 24. FUNERAL DIRECTOR
Mari Lou M. Sowers | | | ADDRESS
HAFFER FUNERAL HOME | | 25a. REC'D BY REGISTRAR
SEP 22 1966 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |
| MARILOU M. SOWERS 60 W. MAIN ST. FROSTBURG | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

12157

CERTIFICATE OF DEATH

12145

| | | | | | | | |
|--|----------------------------------|---|------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE PENNSYLVANIA b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
FAIRHOPE | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
MEMORIAL HOSPITAL | | | | d. STREET ADDRESS | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First GLADYS Middle C. Last SHAFFER | | | | 4. DATE OF DEATH
Month SEPTEMBER Day 13 Year 19 66 | | | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11-2-93 | | 9. AGE (In years lost birthday) yrs. 72 | | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)
housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
HYNDMAN, PA. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
JOHN SHOUP | | | | 14. MOTHER'S MAIDEN NAME
LAURA CLITES | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
78-12-4741 | | 17. INFORMANT
MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Accident - left
331X DUE TO Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO hemiplegia
(c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Coronary Insufficiency; Osteoarthritis | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 6/21 5:45 P.M. 9/13 , 19 66 , that (I) (we) lost saw the deceased alive on 9/12 19 66 , and that death occurred at 9:45 M. from causes on and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Leo H. Ley Jr | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
9/15/66 | |
| 22c. PHYSICIAN'S NAME (Type)
DR. LEO LEY | | | | 22d. ADDRESS
CUMBERLAND, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Sept. 16, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY
Hyndman Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Hyndman, Bedford Co., Pa. | |
| 24. FUNERAL DIRECTOR
Harvey H. Zeigler | | | | ADDRESS
Hyndman, Pa. | | 25a. REC'D BY REGISTRAR
DATE SEP 19 1966 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

15115

CERTIFICATE OF DEATH

15115

PENNSYLVANIA

ALLEGANY

TAUNTON

CHESBROUGH

VENUE HOSPITAL

SHARPE

ALICE

11-2-23

11-2-23

JOHN H. SHARP

JOHN SHARP

LAURA D. SHARP

CHESBROUGH HOSPITAL, CHESBROUGH, PA.

CHESBROUGH HOSPITAL, CHESBROUGH, PA.

CHESBROUGH HOSPITAL, CHESBROUGH, PA.

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CHESBROUGH HOSPITAL, CHESBROUGH, PA.

CHESBROUGH HOSPITAL, CHESBROUGH, PA.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

12152

CERTIFICATE OF DEATH

12146

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. LENGTH OF STAY IN 1b
1 DAY | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CORRIGANVILLE, | | 01-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
MEMORIAL HOSPITAL | | d. STREET ADDRESS | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) MRS. SUSAN M SHAFFER | | 4. DATE OF DEATH
Month September Day 15 Year 1966 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8/17/82 |
| 9. AGE (In years lost birthday)
84 yrs. | | IF UNDER 1 YEAR
Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
PENNSYLVANIA, | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Tobias Miller | | 14. MOTHER'S MAIDEN NAME
Lydia Phillippi | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
MEMORIAL HOSPITAL, CUMBERLAND, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Congestive Heart Failure
4500 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Genl arteriosclerosis
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Uremia | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. 19
p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Jan , 19 66 , to 9-15 , 19 66 that (I) (we) last saw the deceased alive on 9-15 , 19 66 , and that death occurred at 10:35 AM causes and on the date stated above. | | | |
| 22a. SIGNATURE
William P. James | | 22b. DATE SIGNED
9/15/66 | |
| 22c. PHYSICIAN'S NAME (Type)
DR. WILLIAM JAMES | | 22d. ADDRESS
441 N CENTRE ST. CUMBERLAND, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
Sept. 18, 1966 | 23c. NAME OF CEMETERY OR CREMATORY
Hyndman Cemetery | 23d. LOCATION (City or Town) (County) (State)
Hyndman, Bedford Col., Pa. |
| 24. FUNERAL DIRECTOR
Harvey H. Feigler | | 25a. REC'D BY REGISTRAR
DATE SEP 19 1966 | |
| ADDRESS
Hyndman, Pa. | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

12118

STATE OF OHIO

12118

ALLEGANY

WESTVALE

WILEY

CONCORDIAVILLE

CONCORDIAVILLE

CONCORDIAVILLE

SHARPER

SHARPER

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SHARPER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|-------------------------------|---|---|---|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 12147 | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG
c. LENGTH OF STAY IN 1b 1 DAY
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG
d. STREET ADDRESS 31 HAWTHORNE DRIVE BRADDOCK ESTATES
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print)
First WILLIAM Middle HASKELL Last SHIELDS | | | | | 4. DATE OF DEATH
Month SEPTEMBER Day 28 Year 19 66 | | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
MARCH 25, 1900 | | 9. AGE (In years last birthday) 66
IF UNDER 1 YEAR: Months 01 Days 1
IF UNDER 24 HRS: Hours 01 Mins. 01 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JUNIOR EXECUTIVE | | | 10b. KIND OF BUSINESS OR INDUSTRY JOHNS-MANVILLE | | | 11. BIRTHPLACE (County & State, or foreign country) KENTUCKY | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME MILTON SHIELDS | | | | | 14. MOTHER'S MAIDEN NAME MARTHA MC KENNEY | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | | | | 16. SOCIAL SECURITY NO. 086-071-1189 | | | | |
| 17. INFORMANT MRS. WILLIAM H. SHIELDS, 31 HAWTHORNE DRIVE, BRADDOCK ESTATES, FROSTBURG | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PRIMARY HEPATOMA (LEFT)
1550
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 weeks | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. 19
p.m. 9:28 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) FROSTBURG (County) ALLEGANY (State) MD. | | |
| 21. I certify that (I) (this hospital) attended the deceased from July , 19 66 , to 9/28 , 19 66 , that (I) (we) last saw the deceased alive on 9/28 , 19 66 , and that death occurred at 4:40 AM, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE Martin M. Rothstein | | | | | 22b. DATE SIGNED 9/29/66 | | 22c. PHYSICIAN'S NAME (Type) MARTIN M. ROTHSTEIN, M.D. | | |
| 22d. ADDRESS 48 BROADWAY, FROSTBURG, MD. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | 23b. DATE THEREOF OCT. 1, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEM. PARK | | 23d. LOCATION (City, town or county) FROSTBURG, MARYLAND | | |
| 24. FUNERAL DIRECTOR MARILYN M. SOWERS | | | | | 25a. REC'D BY REGISTRAR Charles Judge | | | | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | DATE OCT 3 1966 | | | | |

13117

13117



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DATE 08-11-1980 BY SP-6 JWS/STW
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INFORMATION STORAGE AND RETRIEVAL
SYSTEM, WITHOUT PERMISSION IN WRITING
FROM THE NATIONAL ARCHIVES
COLLECTIONS SERVICE
13117

12154

CERTIFICATE OF DEATH

12148

| | | | |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. LENGTH OF STAY IN yrs.
32 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
MEMORIAL HOSPITAL | | d. STREET ADDRESS
ROUTE 1 | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
MRS. ELIZABETH P. SLIDER | | 4. DATE OF DEATH
Month Day Year
SEPT 16 66 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3/11/98 |
| 9. AGE (In years lost to day)
68 | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired School Teacher | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
THOMAS RICHARDSON | | 14. MOTHER'S MAIDEN NAME
*IDA HUFF | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
MEMORIAL HOSPITAL, CUMBERLAND, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Obstructive jaundice due to Carcinoma, bile ducts
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) 4-6-66
(c) ? | | INTERVAL BETWEEN ONSET AND DEATH
3-6-66
? 6-12-66 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Aug 15, 1966 , to Sept 15, 1966 that (I) (we) last saw the deceased alive on Sept 15, 1966 , and that death occurred at 9:15 AM from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Dr. A. J. Mirkin | | 22b. DATE SIGNED
9/18/66 | |
| 22c. PHYSICIAN'S NAME (Type)
DR. A. J. MIRKIN | | 22d. ADDRESS
115 S CENTRE ST. CUMBERLAND, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Sept 19, 1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Hillcrest Burial Park | | 23d. LOCATION (City or Town) (County) (State)
Cumberland, Allegany Md | |
| 24. FUNERAL DIRECTOR
John J. Hafer | | 25a. REC'D BY REGISTRAR
SEP 20 1966 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12118

CENTRAL OF DEATH

12152

ALL CASES

REMARKS

ALL CASES

OLD TOWN

12 DAYS

CORRECTION

RECEIVED HOSPITAL

ROUTE 1

MASS. HOSPITAL, B. B. 1180

SEPT. 10

RECEIVED WHITE

EXIT 1

WAS LAD

THOMAS RICHARDSON

REMARKS: IN 1911

THE HOSPITAL HOSPITAL, CORRECTION, NO.

NO

DR. A. L. RICHARDSON

THE 2 CENTRAL OF CORRECTION, NO.

REMARKS: IN 1911

REMARKS: IN 1911

REMARKS: IN 1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12155

CERTIFICATE OF DEATH

12149

| | | | |
|---|------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. LENGTH OF STAY IN 1b
1 Day | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cresaptown | | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Sacred Heart Hospital | |
| d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First George Middle L. Last Snyder | | 4. DATE OF DEATH
Month 9 Day 21 Year 1966 | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7/29/96 |
| 9. AGE (In years last birthday)
70 yrs. | | 10. IF UNDER 1 YEAR
Months 9 Days 21 Hours 19 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
retired | | 10b. KIND OF BUSINESS OR INDUSTRY
Celanese Corp. | |
| 11. BIRTHPLACE (County & State, or foreign country)
W. Va. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Samuel Snyder | | 14. MOTHER'S MAIDEN NAME
Laura (Unknown) | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Miles Snyder | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Occlusion
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Acute Bronchitis
DUE TO
(c) Pulmonary Emphysema and Cor Pulmonale. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | INTERVAL BETWEEN ONSET AND DEATH
24 hours ?
1 week
5 years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Sept. 20th, 1966 , to Sept 21st 1966 , that (I) (we) lost saw the deceased alive on Sept. 21st 19 66 , and that death occurred at 2:05 M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>Wyand F. Doerner, Jr.</i> | | 22b. DATE SIGNED
Sept. 22, 1966 | |
| 22c. PHYSICIAN'S NAME (Type)
Wyand F. Doerner, Jr., M.D. | | 22d. ADDRESS
414 N. Mechanic Street, Cumberland, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Sept 24, 1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Levels Cemetary | | 23d. LOCATION (City or Town) (County) (State)
Levels Hampshire W.Va. | |
| 24. FUNERAL DIRECTOR
<i>John J. Hafer</i>
John J. Hafer | | 25a. REC'D BY REGISTRAR
SEP 26 1966 | |
| 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | 25c. ADDRESS
230 Balto Ave., Cumberland, Md | |

12131

DEPARTMENT OF DEATH

12132

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|----------|--|-----|--|--------|--|-------|--|------------|--|----------------|--|------------|--|-------------|--|--------------------|--|-------------------|--|-------------------|--|----------------|--|----------------|--|---------------|--|-----------|--|----------|--|---------|--|
| Name | | Age | | Sex | | Race | | Religion | | Marital Status | | Occupation | | Education | | Previous Residence | | Date of Birth | | Date of Death | | Cause of Death | | Place of Death | | Time of Death | | Signature | | Witness | | Remarks | |
| John Doe | | 35 | | Male | | White | | Catholic | | Married | | Teacher | | High School | | New York City | | January 1, 1920 | | January 1, 1920 | | Heart Disease | | New York City | | 10:00 AM | | John Doe | | Jane Doe | | None | |
| Jane Doe | | 28 | | Female | | White | | Protestant | | Single | | Nurse | | College | | New York City | | February 1, 1920 | | February 1, 1920 | | Pneumonia | | New York City | | 11:00 AM | | Jane Doe | | John Doe | | None | |
| John Doe | | 45 | | Male | | White | | Jewish | | Married | | Engineer | | University | | New York City | | March 1, 1920 | | March 1, 1920 | | Stroke | | New York City | | 12:00 PM | | John Doe | | Jane Doe | | None | |
| Jane Doe | | 30 | | Female | | White | | Catholic | | Single | | Teacher | | High School | | New York City | | April 1, 1920 | | April 1, 1920 | | Heart Disease | | New York City | | 1:00 PM | | Jane Doe | | John Doe | | None | |
| John Doe | | 50 | | Male | | White | | Protestant | | Married | | Engineer | | University | | New York City | | May 1, 1920 | | May 1, 1920 | | Stroke | | New York City | | 2:00 PM | | John Doe | | Jane Doe | | None | |
| Jane Doe | | 25 | | Female | | White | | Catholic | | Single | | Teacher | | High School | | New York City | | June 1, 1920 | | June 1, 1920 | | Pneumonia | | New York City | | 3:00 PM | | Jane Doe | | John Doe | | None | |
| John Doe | | 38 | | Male | | White | | Jewish | | Married | | Engineer | | University | | New York City | | July 1, 1920 | | July 1, 1920 | | Stroke | | New York City | | 4:00 PM | | John Doe | | Jane Doe | | None | |
| Jane Doe | | 22 | | Female | | White | | Protestant | | Single | | Teacher | | High School | | New York City | | August 1, 1920 | | August 1, 1920 | | Heart Disease | | New York City | | 5:00 PM | | Jane Doe | | John Doe | | None | |
| John Doe | | 42 | | Male | | White | | Catholic | | Married | | Engineer | | University | | New York City | | September 1, 1920 | | September 1, 1920 | | Stroke | | New York City | | 6:00 PM | | John Doe | | Jane Doe | | None | |
| Jane Doe | | 27 | | Female | | White | | Jewish | | Single | | Teacher | | High School | | New York City | | October 1, 1920 | | October 1, 1920 | | Pneumonia | | New York City | | 7:00 PM | | Jane Doe | | John Doe | | None | |
| John Doe | | 48 | | Male | | White | | Protestant | | Married | | Engineer | | University | | New York City | | November 1, 1920 | | November 1, 1920 | | Stroke | | New York City | | 8:00 PM | | John Doe | | Jane Doe | | None | |
| Jane Doe | | 23 | | Female | | White | | Catholic | | Single | | Teacher | | High School | | New York City | | December 1, 1920 | | December 1, 1920 | | Heart Disease | | New York City | | 9:00 PM | | Jane Doe | | John Doe | | None | |

12156

CERTIFICATE OF DEATH

12150

| | | | |
|--|-------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. LENGTH OF STAY IN 1b
3 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
MEMORIAL HOSPITAL | | d. STREET ADDRESS
MIDLAND | |
| 3. NAME OF DECEASED (Type or print)
First WILLIAM Middle H. Last SPIKER | | 4. DATE OF DEATH
Month SEPT. Day 28. Year 1966 | |
| 5. SEX MALE
WXXXX | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11-11-1913 |
| 9. AGE (In years last birthday)
52 yrs. | | 10. IF UNDER 1 YEAR
Months _____ Days _____ Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
MT. SAVAGE, MD. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
EDGAR SPIKER | | 14. MOTHER'S MAIDEN NAME
MEME MC DONALD | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
MEMORIAL HOSPITAL, CUMBERLAND, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral infarction
DUE TO (b) Hypertension
DUE TO (c) cerebral arteriosclerosis
INTERVAL BETWEEN ONSET AND DEATH 3 days | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
9/25/66 | | 20f. (City or town) 9/25/66 (County) _____ (State) _____ | |
| 21. I certify that (I) (this hospital) attended the deceased from 9/25/66 , to 9/27/66 , that (I) (we) last saw the deceased alive on 9/27/66 , and that death occurred at 5:50 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
[Signature] | | 22b. DATE SIGNED
9/28/66 | |
| 22c. PHYSICIAN'S NAME (Type)
DR. S. G. WEISMAN | | 22d. ADDRESS
59 GREENE ST., | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10/1/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Frostburg Memorial Park | | 23d. LOCATION (City or Town) (County) (State)
Frostburg A. Md | |
| 24. FUNERAL DIRECTOR
George Eichhorn | | 25a. REC'D BY REGISTRAR
Oct 3 1966 | |
| 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then (please) remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12150

12150

ALLEGANY

ALLEGANY

CHURCHMAN

3 DAYS

INTEND

MEMORIAL HOSPITAL

WILLIAM

SPICER

APRIL 22, 1908

NAME

WHITE

11-11-1913

22

MT. SAVAGE, W.

U. S. A.

EDWARD SPICER

MEME MC DONALD

MEMORIAL HOSPITAL, CHURCHMAN, W.

U. S. A. WESTERN

35 CRENSHAW

10/1/00

Postbury Memorial Park, Woodbury, A.

George Simpson

CHURCHMAN, W.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and return event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12157

12151

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md.
b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
rural Westernport | | c. LENGTH OF STAY IN 1b
Min-s | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
State Rt. 135 | | e. STREET ADDRESS
235 Greene | |
| 3. NAME OF DECEASED (Type or print)
First Mary Middle Elizabeth Last Terrell | | 4. DATE OF DEATH
Month Sept Day 2 Year 1966 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
April 6, 1915 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Lab. technician | | 10b. KIND OF BUSINESS OR INDUSTRY
Paper Mill | 9. AGE (In years last birthday)
51 yrs. |
| 11. BIRTHPLACE (State or foreign country)
W. Va. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Everett Springer | | 14. MOTHER'S MAIDEN NAME
Carrie Harr | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
214-34-1363 | 17. INFORMANT
Michael Stakem
Address Frostburg, Md. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 8164 Ruptured Heart
DUE TO (b) Crushed Chest
DUE TO (c) "
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | INTERVAL BETWEEN ONSET AND DEATH
Sudden |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Passenger in a two car accident | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 10:45 p.m. Sept. 2 19 66 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Street | 20f. (City or town) (County) (State)
Near McCoole, Allegany, Maryland |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Benedict Skitarelic M.D. | | 22. DATE SIGNED
Sept. 3, 1966 | |
| EXAMINER'S NAME (Type) Benedict Skitarelic, M.D. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Sept. 3, 1966
Address (Street, city, town, or county) Cumberland, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
9/6/66 | 23c. NAME OF CEMETERY OR CREMATORY
St. Peters | 23d. LOCATION (City or Town) (County) (State)
Westernport Md. |
| 24. FUNERAL DIRECTOR
E.S. Boal
<i>E.S. Boal</i> | | 25a. REC'D BY REGISTRAR
DATE SEP 3 1966 | |
| ADDRESS
Westernport, Md. | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|---|--|------------------|--|---|--|---|--|---|-----------------------|------------------------|--|
| 12158 | | | | | | 12152 | | | | | |
| 1. PLACE OF DEATH | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) | | | | | |
| a. COUNTY | | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | a. STATE | | | b. COUNTY | | |
| Allegany | | | MARYLAND | | | Maryland | | | Allegany | | |
| c. LENGTH OF STAY IN TB | | | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | d. STREET ADDRESS | | |
| 2 Days | | | Frostburg | | | Frostburg | | | 247 Lower Consol Road | | |
| 3. NAME OF DECEASED (Type or print) | | | | | | 4. DATE OF DEATH | | | | | |
| First | | Middle | | Last | | Month | | Day | | Year | |
| Samuel | | Israel | | Thomas, Sr. | | September | | 9 | | 1966 | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | B. DATE OF BIRTH | | 9. AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| Male | | White | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Sept 27, 1902 | | 63 yrs. | | Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (County & State, or foreign country) | | | |
| Retired | | | | Celanese Corp | | | | Allegany Co., Maryland | | | |
| 13. FATHER'S NAME | | | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| John B. Thomas | | | | | | Ada Walbert Thomas Walbert | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | | |
| (If yes give year or dates of service) | | | | | | | | George A. Thomas, Route 2, Box 293, Frostburg | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Gastric Hemorrhage | | | | | | | | | | | |
| 5410 DUE TO (b) Possible Peptic Ulcer | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive - & Coronary Artery Heart Disease - Aortic Insufficiency | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 X | | | | | | | | | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | | | | | | |
| 20f. (City or town) (County) (State) | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 9/6, 1966 to 9/9, 1966, that (I) (we) last saw the deceased alive on 9/9, 1966, and that death occurred at 9:10 PM, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE Martin M. Rothstein M.D. | | | | | | | | | | | |
| 22b. DATE SIGNED 9/10/66 | | | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) MARTIN M. ROTHSTEIN M.D. 48 BROADWAY - FROSTBURG - MD 21572 | | | | | | | | | | | |
| 22d. ADDRESS | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | | | | | | |
| 23b. DATE THEREOF Sept 12, 1966 | | | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park | | | | | | | | | | | |
| 23d. LOCATION (City, town or county) (State) Frostburg, Maryland | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer ADDRESS 230 Balto Ave. Cumberland, Md | | | | | | | | | | | |
| 25a. REC'D BY REGISTRAR DATE SEP 14 1966 | | | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | |

12152

12152

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CERTIFICATE OF DEATH

12153

12159

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY GARRETT | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. LENGTH OF STAY IN 1b
4 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
MEMORIAL HOSPITAL | | d. STREET ADDRESS
BOX 36 | |
| 3. NAME OF DECEASED (Type or print)
First LIDIA Middle L Last TICHNELL | | 4. DATE OF DEATH
Month SEPTEMBER Day 8 Year 19 66 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 893
3-2-1883 |
| 9. AGE (In years last birthday)
73 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | |
| 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
HENRY BARNARD | |
| 14. MOTHER'S MAIDEN NAME
RACHEL WARNICK | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
MEMORIAL HOSPITAL, CUMBERLAND MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arterio Sclerotic Cardiovas. dis.
4221 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c) Generalized Arterio Sclerosis | | INTERVAL BETWEEN ONSET AND DEATH
seen 12:30. 9 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | |
| 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 21. I certify that (I) (his hospital) attended the deceased from 12:30. , 19 88 , to 9-8- , 19 66 , that (I) (we) saw the deceased alive on 9-8- , 19 66 and that death occurred at 12:55 p.m. from causes and on the date stated above. | |
| 22a. SIGNATURE
W. F. Williams M.D. | | 22b. DATE SIGNED
9-9-66 | |
| 22c. PHYSICIAN'S NAME (Type)
DR. W. F. WILLIAMS | | 22d. ADDRESS
122 S. CENTRE ST. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
9/11/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Philos Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Westernport Ft Allegany Md. | |
| 24. FUNERAL DIRECTOR
E. S. Beal | | 25a. REC'D BY REGISTRAR
SEP 14 1966 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

12150

18150

CRIMINAL RECORD

ALLEGANY

MARYLAND

GARRETT

CHANDLER

2 DAYS

BLOOMINGTON

MEMORIAL HOSPITAL

BOX 30

LIDIA

TICHNET

TESTED

REAR WHITE

2-11-13

OUR HOME

MARYLAND

PERRY BARNARD

RACHEL BARNICK

MEMORIAL HOSPITAL, BLOOMINGTON, MD.

122 S. CENTRE ST.

DR. J. E. WILLIAMS

Union Cemetery

12150

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12160

CERTIFICATE OF DEATH

12155

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|--|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. LENGTH OF STAY IN 1b
27 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
MEMORIAL HOSPITAL | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First WILLIAM A. Middle August Last WEBER | | 4. DATE OF DEATH
Month SEPT Day 26 Year 66 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2-21-1917 |
| 9. AGE (In years last birthday)
49 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Heavy equip. opr. | |
| 11. BIRTHPLACE (County & State, or foreign country)
CUMBERLAND, MD. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
GEORGE W. WEBER | | 14. MOTHER'S MAIDEN NAME
EFFIE FROST | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
214-07-0636 | |
| 17. INFORMANT
MEMORIAL XXX HOSPITAL, CUMB. MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA OF GALL Bladder with
DUE TO (b) metastasis to the Liver
DUE TO (c) TERMINAL Cachexia | | INTERVAL BETWEEN ONSET AND DEATH
1 year plus 1 year? | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from JUNE 27, 1966 , to SEP 26, 1966 that (I) (we) last saw the deceased alive on SEP 26, 1966 , and that death occurred at 7:35 PM from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Wylie M Fawcett | | 22b. DATE SIGNED
SEP 27, 1966 | |
| 22c. PHYSICIAN'S NAME (Type)
DR. WYLIE FAW | | 22d. ADDRESS
122 S. CENTRE ST. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
9/29/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY
St. Luke's Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Cumberland, Allegany Md. | |
| 24. FUNERAL DIRECTOR
H. Wayne George Cumberland, Md. | | 25a. REC'D BY REGISTRAR
OCT 3 1966 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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00151

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

12161

CERTIFICATE OF DEATH

12156

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
ALLEGANY
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. LENGTH OF STAY IN 1b
LIFE | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
SACRED HEART HOSPITAL | | d. STREET ADDRESS
308 ARCH STREET | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
ERNEST SYLVESTER WEISENMILLER | | 4. DATE OF DEATH
Month Day Year
SEPTEMBER 9, 1966 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED
<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1-27-1896 |
| 9. AGE (In years lost birthday) yrs.
70 | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | | 11. BIRTHPLACE (County & State, or foreign country)
MARYLAND | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
JACOB WEISENMILLER | |
| 14. MOTHER'S MAIDEN NAME
ELEANOR (YUPA) WEISENMILLER | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
yes War I | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
PTS. CHART | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4221
DUE TO Uraemia
(b) Myocardial & Decompensation
DUE TO Atherosclerosis
(c) Septic | | INTERVAL BETWEEN ONSET AND DEATH
7 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from June , 19 65 , to Sept 9 , 19 66 that (I) (we) last saw the deceased alive on Sept 9 , 19 66 and that death occurred at 9:11 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Clay E. Durrett | | 22b. DATE SIGNED
9/11/66 | |
| 22c. PHYSICIAN'S NAME (Type)
CLAY E. DURRETT, M.D. | | 22d. ADDRESS
236 Virginia Ave. Cumberland, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
Sept. 12, 1966 | 23c. NAME OF CEMETERY OR CREMATORY
St. Mary's Cemetery | 23d. LOCATION (City or Town) (County) (State)
Cumberland, Md. Allegany |
| 24. FUNERAL DIRECTOR
James F. Scarpelli, Cumberland, Md. | | 25a. REC'D BY REGISTRAR
DATE SEP 14 1966 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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1 (M)
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12162

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12157

| | | | | | | | |
|--|----------------------------------|---|--|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>CUMBERLAND</u> | | c. LENGTH OF STAY IN lb
<u>LIFE</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>CUMBERLAND</u> <u>01-1</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>524 CUMBERLAND STREET</u> | | | | d. STREET ADDRESS
<u>524 CUMBERLAND STREET</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>SAMUEL G. WEISKETTEL</u> | | | | 4. DATE OF DEATH
Month Day Year
<u>SEPT. 29 19 66</u> | | | |
| 5. SEX
<u>MALE</u> | 6. COLOR OR RACE
<u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>JULY 13, 1891</u> | | 9. AGE (In years last birthday)
<u>75</u> yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>SALESMAN</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>FOOD</u> | | 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>GEORGE W. WEISKETTEL</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>LUCY TRANARY</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>214 05 5811</u> | | 17. INFORMANT
<u>MRS. FRANCES THOMAS</u> | | Address
<u>CUMBERLAND, MD.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4201</u> <u>CORONARY OCCLUSION</u>
DUE TO
(b) <u>CORONARY SCLEROSIS</u>
DUE TO
(c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>SUDDEN</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
<u>Benedict Skitarelic</u>
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22. DATE SIGNED
<u>September 29, 1966</u>
Address (Street, city, town, or county) <u>Cumberland, Maryland</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>OCT. 2, 1966</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>GREENMOUNT CEMETERY</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>CUMBERLAND, MD.</u> | |
| 24. FUNERAL DIRECTOR
<u>BYRON KIGHT</u> | | | | 25a. REC'D BY REGISTRAR
DATE <u>OCT 3 1966</u> | | 25b. REGISTRAR'S SIGNATURE
<u>f Charles Judge</u> | |

18181

18181

CERTIFICATE OF DEATH

12168

12158

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. LENGTH OF STAY IN 1b
20 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
MEMORIAL HOSPITAL | | e. STREET ADDRESS
RT 2 HAZEN RD. BOX 786 | |
| 3. NAME OF DECEASED (Type or print)
First EMANUEL Middle P Last WELSH | | 4. DATE OF DEATH
Month SEPT Day 20 Year 66 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9-25-1-1889 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Carman Helper B&O RR Forge | | 10b. KIND OF BUSINESS OR INDUSTRY
Boit & Forge | 9. AGE (In years last birthday) yrs.
77 |
| 11. BIRTHPLACE (County & State, or foreign country)
CUMBERLAND, MD. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
JOHN WELSH | | 14. MOTHER'S MAIDEN NAME
ANNABELLE *WELSH (UNKNOWN) | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
220-10-2501A | |
| 17. INFORMANT
MEMORIAL HOSPITAL, CUMBERLAND, MD | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Terminal Cardiac Failure
443X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO (b) Pneumonia, H. L. lob. acute,
DUE TO (c) Hypertension & A.S. Coronary disease | | | INTERVAL BETWEEN ONSET AND DEATH
3 weeks
10 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Gen. arteriosclerosis Diabetes mellitus | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 1 Sept. , 19 66 , to 20 Sept. , 19 66 ; that (I) (we) last saw the deceased alive on 20 Sept. , 19 66 , and that death occurred at 12:05 PM on 20 Sept. , 19 66 , and that death was caused by the causes and on the date stated above. | | | |
| 22a. SIGNATURE
W. Alfred Van Ormer, M.D. | | 22b. DATE SIGNED
20 Sept. 66 | |
| 22c. PHYSICIAN'S NAME (Type)
DR. W A VAN ORMER | | 22d. ADDRESS
122 S CENTER ST. CUMBERLAND, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
Sept. 23, 1966 | 23c. NAME OF CEMETERY OR CREMATORY
Bald Hill Cemetery | 23d. LOCATION (City or Town) (County) (State)
Near Cumberland Allegany Md |
| 24. FUNERAL DIRECTOR
John J. Hafer, 230 Balto Ave. Cumberland, Md | | 25a. REC'D BY REGISTRAR
SEP 26 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15154

CERTIFICATE OF DEATH

15154

ALL EMBALM

WASH STATE

ALL EMBALM

CUMBERLAND

60 DAYS

CUMBERLAND

AT 2 HAZEN RD. BOX 996

MEMORIAL HOSPITAL

WELSH T. J. JR. 2897

EMANUEL

WHITE

CUMBERLAND, W. V. 2600

1915

John G. Gorman, Jr. B. S. 1915

ANNABELLE WHITE (CUMBERLAND)

JOHN WHITE

MEMORIAL HOSPITAL, CUMBERLAND

200-10-1000

| | | | |
|-------------------------|--|--------------------------|--|
| 1. Name of deceased | | 2. Date of death | |
| 3. Place of death | | 4. Cause of death | |
| 5. Age at death | | 6. Sex | |
| 7. Race | | 8. Marital status | |
| 9. Occupation | | 10. Education | |
| 11. Date of birth | | 12. Date of death | |
| 13. Place of birth | | 14. Place of death | |
| 15. Name of physician | | 16. Name of funeral home | |
| 17. Name of next of kin | | 18. Name of informant | |
| 19. Name of registrar | | 20. Name of witness | |
| 21. Name of witness | | 22. Name of witness | |
| 23. Name of witness | | 24. Name of witness | |
| 25. Name of witness | | 26. Name of witness | |
| 27. Name of witness | | 28. Name of witness | |
| 29. Name of witness | | 30. Name of witness | |
| 31. Name of witness | | 32. Name of witness | |
| 33. Name of witness | | 34. Name of witness | |
| 35. Name of witness | | 36. Name of witness | |
| 37. Name of witness | | 38. Name of witness | |
| 39. Name of witness | | 40. Name of witness | |
| 41. Name of witness | | 42. Name of witness | |
| 43. Name of witness | | 44. Name of witness | |
| 45. Name of witness | | 46. Name of witness | |
| 47. Name of witness | | 48. Name of witness | |
| 49. Name of witness | | 50. Name of witness | |
| 51. Name of witness | | 52. Name of witness | |
| 53. Name of witness | | 54. Name of witness | |
| 55. Name of witness | | 56. Name of witness | |
| 57. Name of witness | | 58. Name of witness | |
| 59. Name of witness | | 60. Name of witness | |
| 61. Name of witness | | 62. Name of witness | |
| 63. Name of witness | | 64. Name of witness | |
| 65. Name of witness | | 66. Name of witness | |
| 67. Name of witness | | 68. Name of witness | |
| 69. Name of witness | | 70. Name of witness | |
| 71. Name of witness | | 72. Name of witness | |
| 73. Name of witness | | 74. Name of witness | |
| 75. Name of witness | | 76. Name of witness | |
| 77. Name of witness | | 78. Name of witness | |
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| 81. Name of witness | | 82. Name of witness | |
| 83. Name of witness | | 84. Name of witness | |
| 85. Name of witness | | 86. Name of witness | |
| 87. Name of witness | | 88. Name of witness | |
| 89. Name of witness | | 90. Name of witness | |
| 91. Name of witness | | 92. Name of witness | |
| 93. Name of witness | | 94. Name of witness | |
| 95. Name of witness | | 96. Name of witness | |
| 97. Name of witness | | 98. Name of witness | |
| 99. Name of witness | | 100. Name of witness | |

12164

CERTIFICATE OF DEATH

12159

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND | | c. LENGTH OF STAY IN lb
20 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
MEMORIAL HOSPITAL | | e. STREET ADDRESS
RT. 2, WILLIAMS RD. | |
| 3. NAME OF DECEASED (Type or print)
First THOMAS Middle B. Last WHETZEL | | 4. DATE OF DEATH
Month SEPT. Day 21. Year 1966 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2-17-1902 |
| 9. AGE (In years last birthday)
64 yrs. | | 10. IF UNDER 1 YEAR
Months 1 Days 21 Hours 19 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Utility Man | | 10b. KIND OF BUSINESS OR INDUSTRY
Railroad | |
| 11. BIRTHPLACE (County & State, or foreign country)
MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
BEN WHETZEL (Benjamin) | | 14. MOTHER'S MAIDEN NAME
BARBARA PARKER | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
MEMORIAL HOSPITAL, CUMBERLAND, MD. | |
| 17. INFORMANT
MEMORIAL HOSPITAL, CUMBERLAND, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 163X Uraemia
DUE TO (b) Carcinoma Left Lung
DUE TO (c) 7mon | | INTERVAL BETWEEN ONSET AND DEATH
7mon | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 19 o.m. p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Sept. 10, 1966 to Sept. 21, 1966 that (I) (we) last saw the deceased alive on 19 , and that death occurred at 8:45 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Clay E. Durrett | | 22b. DATE SIGNED
9/22/66 | |
| 22c. PHYSICIAN'S NAME (Type)
DR. CLAY DURRETT | | 22d. ADDRESS
236 VIRGINIA AVE. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Sept. 25, 1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Zion Memorial Park | | 23d. LOCATION (City or Town) (County) (State)
Cumberland, Md. Allegany | |
| 24. FUNERAL DIRECTOR
James F. Scarpelli, Cumberland, Md. | | 25a. REC'D BY REGISTRAR
SEP 28 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

15150

CENTRAL OF IN

15151

ALLEGANY

WHEELAND

ALLEGANY

WHEELAND

20 DAYS

PT. S. WILLIAMS

HOSPITAL

3735

THOMAS

8-1-1905

MALE

BARBARA JANKO

BOB JANKO

HOSPITAL

23 THOMAS AVE.

DR. CLAY CURRIE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12165

12160

| | | | |
|---|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. LENGTH OF STAY IN 1b
D O A | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Sacred Heart Hospital | | d. STREET ADDRESS
Route 1 | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Frederick Perrin Willison | | 4. DATE OF DEATH
Month Day Year
September 18 1966 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 8, 1916 |
| 9. AGE (In years last birthday) yrs.
50 | | 10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Salesman & Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U S A | |
| 13. FATHER'S NAME
Norval Willison | | 14. MOTHER'S MAIDEN NAME
Judy Perrin | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Mrs. Paul Bucholtz, 221 Nat'l Hwy, La Vale, Md | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis, Right
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Coronary Sclerosis
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | INTERVAL BETWEEN ONSET AND DEATH
Sudden
---- | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Benedict Skitarellic M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D. | | 22. DATE SIGNED September 18, 1966 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Sept 21, 1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY
IOOF Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Flintstone Allegany Md | |
| 24. FUNERAL DIRECTOR
John J. Hafer, 230 Balto Ave. Cumberland, Md | | 25a. REC'D BY REGISTRAR
SEP 20 1966 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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FOR STATE
HEALTH DEPT

12166

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12161

| | | | | | |
|--|--|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Garrett | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. LENGTH OF STAY IN lb
10 days | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural - Gorman, W. Va. | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
208 Spring Street | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First NELLIE Middle MAE Last WILSON | | | 4. DATE OF DEATH
Month September Day 26 Year 1966 | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
Sept. 16, 1887 | | 9. AGE (In years last birthday) yrs. 79 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)
housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own home | 11. BIRTHPLACE (State or foreign country)
Edinburg, Virginia | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
Marcus P. Jack | | | 14. MOTHER'S MAIDEN NAME
Virginia Clem | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Son)
Richard Wilson, Spring Hill, W. Va. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Coronary Sclerosis
DUE TO (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH
Sudden
--- |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE Benedict Skitarelic M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22. DATE SIGNED September 26, 1966 | |
| EXAMINER'S NAME (Type) Benedict Skitarelic, M.D. | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | Address (Street, city, town, or county) Cumberland, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | 23b. DATE THEREOF 9/30/66 | 23c. NAME OF CEMETERY OR CREMATORY Beinhauer Crematory | 23d. LOCATION (City or Town) (County) (State) Pittsburgh, Alleg. Pa. | | |
| 24. FUNERAL DIRECTOR O. Durst ADDRESS Leighton-Durst Funeral Home, Oakland, Md. | | 25a. REC'D BY REGISTRAR SEP 30 1966 | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12167

CERTIFICATE OF DEATH

12162

| | | | |
|---|----------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY
ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CUMBERLAND
c. LENGTH OF STAY IN lb
2 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
MEMORIAL HOSPITAL | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY GARRETT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SWANTON
d. STREET ADDRESS
11-2
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
PERRY WILLIAM WILT | | 4. DATE OF DEATH
Month Day Year
SEPT. 14 1966 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
12-5-1893 |
| 9. AGE (In years last birthday)
72 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min.
14 19 66 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
SWANTON, MD. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
CEPHAS WILT | | 14. MOTHER'S MAIDEN NAME
ELIZA V. DARR | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service)
Yes W.W. I | | 16. SOCIAL SECURITY NO.
214-16-2257 | |
| 17. INFORMANT
MEMORIAL HOSPITAL, CUMBERLAND, MD. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive Hemorrhage
5421 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) Perforated Marginal ulcer, Stomach DUE TO
(c) 2d | | INTERVAL BETWEEN ONSET AND DEATH
15 min. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Sore abdominal Aortic Aneurysm, A&H | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 9-12 , 19 66 , to 9-14 , 19 66 , that (I) (we) last saw the deceased alive on 9-14 , 19 66 , and that death occurred at 12:30 PM from causes and on the date stated above. | | | |
| 22a. SIGNATURE
William P. James | | 22b. DATE SIGNED
9/14/66 | |
| 22c. PHYSICIAN'S NAME (Type)
DR. W. P. JAMES | | 22d. ADDRESS
441 N. CENTRE ST. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
9/17/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Gaster | | 23d. LOCATION (City or town) (County) (State)
Garrett County Md. | |
| 24. FUNERAL DIRECTOR
W. J. Bral | | 24a. REC'D BY REGISTRAR
DATE SEP 26 1966 | |
| ADDRESS
Westernport, Md. | | 24b. REGISTRAR'S SIGNATURE
Charles Judge | |

15163

15163

CONTRACT ON DEATH

STEEBAY

WILLIAM

STEEBAY AND

2 DAYS

STEEBAY

ORIGINAL INVENTION

PERBY

WILLIAM

TEST

WILLIAM

WILLIAM

ELDER W. DARR

PERBY W. DARR

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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12168

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12168

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland | | c. LENGTH OF STAY IN 1b
3 days | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Cumberland, |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Sacred Heart Hospital | | d. STREET ADDRESS
360 Frederick Street | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print)
First Joseph, Middle Edward Last Wolford | | 4. DATE OF DEATH
Month Sept. Day 3 Year 19 66 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
12/1/05 |
| 9. AGE (In years last birthday) yrs. 60 | | IF UNDER 1 YEAR
Months 9 Days | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Technician | | 10b. KIND OF BUSINESS OR INDUSTRY
Amusement Co. | 11. BIRTHPLACE (County & State, or foreign country)
Cumberland, Md. |
| 12. CITIZEN OF WHAT COUNTRY?
U.S. A. | | 13. FATHER'S NAME
Edward Wolford | |
| 14. MOTHER'S MAIDEN NAME
Mary (Wolford) Wolford | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No. | |
| 16. SOCIAL SECURITY NO.
214-05-6227 | | 17. INFORMANT
Mrs. Irene O. Wolford 360 Frederick St.
Patient's chart | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Occlusion with shock
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) Coronary arteriosclerosis DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH
4 1/2 days
years (?) | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Pulmonary Emphysema; arthritis | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Nat While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from August 31 , 19 66 , to Sept. 3 , 19 66 , that (I) (we) last saw the deceased alive on Sept. 3rd , 19 66 , and that death occurred at 10:50 , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Wyand F. Doerner, Jr., M.D. | | 22b. DATE SIGNED
Sept. 5, 1966 | |
| 22c. PHYSICIAN'S NAME (Type)
Dr. Doerner | | 22d. ADDRESS
826 Windsor Road 414 N. Mechanic St. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
9/6/66 | 23c. NAME OF CEMETERY OR CREMATORY
Hillcrest Burial Park | 23d. LOCATION (City or Town) (County) (State)
Cumberland, Allegany Md. |
| 24. FUNERAL DIRECTOR
H. Wayne George Cumberland, Maryland | | 25a. REC'D BY REGISTRAR
DATE SEP 8 1966 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

VR A15 (4)
20 M 1/66

15168